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

ITEM: 3.18
(ID # 11549)
MEETING DATE:
Tuesday, February 11, 2020

FROM: HUMAN RESOURCES:

SUBJECT: HUMAN RESOURCES: Approval of the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan Professional Service Agreement for the HealthInvest HRA between County of Riverside and Gallagher Benefit Services, Inc.; Master Trust Adoption Agreement for the HealthInvest HRA Master Trust; Amended and Restated Trust Agreement between County of Riverside and Washington Trust Bank, and HealthInvest HRA Plan Adoption Agreement between County of Riverside and Gallagher Benefit Services, Inc.; All Districts. [$0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Approve the Professional Service Agreement for HealthInvest HRA between County of Riverside and Gallagher Benefit Services, Inc. to provide Third-Party Administration recordkeeping services for the County of Riverside's Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan as outlined and specified in the Plan Adoption Agreement effective March 1, 2020 (Attachment A); and
2. Approve the Master Trust Adoption Agreement for the HealthInvest HRA Master Trust by and among Washington Trust Bank ("Master Trustee"), Gallagher Benefit Services, Inc. ("HRA Service Manager"), and the County of Riverside ("Plan Sponsor") effective March 1, 2020 (Attachment B); and

Brenda Diederichs
Brenda Diederichs, Assistant CEO / Human Resources Director 12/30/2019

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	February 11, 2020
xc:	HR

Kecia R. Harper
Clerk of the Board
By: _____
Deputy

3. Approve the Amended and Restated Trust Agreement for the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan dated March 1, 2020 by and between County of Riverside, and Washington Trust Bank ("Trustee"). Washington Trust Bank as Trustee holds assets exempt from taxation under IRS Section 501(c)(9) and acts as the Investment Manager for the Post-Employment Health Savings Plan. (Attachment C); and
4. Approve the HealthInvest HRA Plan Adoption Agreement that approves formal authorization and adoption of the HealthInvest HRA Plan, and approves the use of the Gallagher Benefits Services, Inc. proprietary HealthInvest HRA plan coverage documents governing terms and conditions to implement its HRA plan and the engagement of service providers for the HealthInvest HRA Plan to assist the County of Riverside ("Plan Sponsor") in the administration of its HRA plan. (Attachment D) and the associated coverage documents and summary plan (Attachments E, F and G);
5. Authorize the Chairman of the Board of Supervisors to execute the above referenced agreements on behalf of the County of Riverside.
6. Direct the Clerk of the Board to retain one (1) copy of each signed agreement and return three (3) copies of each signed agreement to Human Resources for distribution.

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: 19/20	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The County of Riverside Post Employment Program was approved by the Board on November 26, 2002, Agenda Item No. 3.39 with an effective date of December 1, 2002. The program consists of the Voluntary Employees' Beneficiary Association (VEBA) Health Savings Plan which is a health reimbursement arrangement ("HRA") that provides employees with post-employment health expense reimbursement that may be used for qualified out-of-pocket healthcare expenses as governed by the IRS Code Section 213(d) and are outlined in IRS Publication 502. The County does not pay Social Security taxes on any amounts deposited into this plan, and the participant does not pay state, federal, or social security taxes on the amounts deposited. The funds in these accounts earns interest and participants can direct the investment of their accounts using multiple fund options in which their leave balances contributions will be invested. There are approximately 2,266 participants in the plan with assets totaling $53.5 million as of September 30, 2019.

The County of Riverside including the Districts maintains a workforce of over 20,000 employees, with more than 40 departments and agencies. Currently, the County's Management,

Confidential, Unrepresented, Deputy District Attorneys Association (DDAA) and Law Enforcement Management Unit (LEMU) employees who retire or end their employment with the County, and have at least five years of County service, have the option to contribute their eligible leave accruals into either the VEBA Health Savings Plan or to the 401(a) Special Pay Plan. Employees represented by the Employees' International Union (SEIU) and Laborers' International Union of North America (LIUNA) who retire from the county are required to contribute their eligible leave accruals to the VEBA Health Savings Plan.

Request for Proposal (RFP) Process and Award #HRARC-073

The County currently contracts with Washington Trust (Trustee and Custodian), Gallagher (Plan Consultant), Rehn and Associates (Third-Party Administrator to effectively and efficiently administer the Post Employment VEBA Health Savings Plan for the County.

The County of Riverside Purchasing Department on behalf of the Human Resources released a proposal for the County's VEBA Post Employment Program (PEP) Health Savings Plan.

The purpose of this RFP was to obtain and engage a qualified vendor and/or vendors to provide Third-Party Administration (TPA) services, Consulting Services, Trustee/Custodian services, and Investment Manager/Advisor services. The RFP Award resulted in the selection of Gallagher Benefit Services, Inc. as the qualified vendor for proposed services. Gallagher has been in the HRA and employee benefits consulting industry for 30+ years.

The subcontractors engaged by Gallagher as part of the HealthInvest HRA bundled service package includes:

Gallagher Benefits Services, Inc. ("GBS")
Gallagher Fiduciary Advisors, Inc. ("GFA")
Washington Trust Bank

The agreements have been approved as to form by County Counsel.

Impact on Residents and Businesses

There is no financial impact to the residents and businesses as a result of the recommended action.

Other Financial Information

The terms of the Agreement in Section 3.1 state County shall pay for expenses according to Exhibit A (administrative and other miscellaneous plan fees) in an amount not to exceed $150,000 annually. These payments will be funded by existing Plan assets so there is no direct affect on the County's budget and the cost of this Agreement is $0.

ATTACHMENTS:

Attachment A:	Professional Services Agreement for HealthInvest between County of Riverside and Gallagher Benefit Services, Inc.
Attachment B:	Master Trust Adoption Agreement for the HealthInvest HRA Master Trust between Washington Trust Bank, Gallagher Benefit Services, Inc., and the County of Riverside
Attachment C:	Amended and Restated Trust Agreement for the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan between Washington Trust Bank and the County of Riverside
Attachment D:	HealthInvest HRA Plan Adoption Agreement
Attachment E:	HealthInvest HRA Plan Coverage Document – Limited HRA Coverage
Attachment F:	HealthInvest HRA Plan Coverage Document Full 213(d) Expense Coverage
Attachment G:	Gallagher | HealthInvest HRA Summary Plan Description

Attachment A

PROFESSIONAL SERVICES AGREEMENT FOR HEALTHINVEST HRA

Professional Services Agreement for HealthInvest HRA effective March 1, 2020
between County of Riverside and Gallagher Benefit Services, Inc.

FEB 11 2020 3.18

PROFESSIONAL SERVICE AGREEMENT

for

HEALTHINVEST HRA

between

COUNTY OF RIVERSIDE

and

GALLAGHER BENEFIT SERVICES, INC.

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This Agreement, made and entered into this 1st day of March, 2020, by and between GALLAGHER BENEFIT SERVICES, INC. , (herein referred to as "CONTRACTOR"), and the COUNTY OF RIVERSIDE, a political subdivision of the State of California, (herein referred to as "COUNTY"). The parties agree as follows:

1. Description of Services

1.1 CONTRACTOR shall provide all services as outlined and specified in Plan Adoption Agreement to include Attachments B,C, and D, and all exhibits and addenda attached hereto, as amended from time to time in accordance with its terms, consisting of 116 pages, at the prices stated in Exhibit A, Payment Provisions, consisting of 2 pages, and Exhibit B, HIPAA Business Associate Agreement, consisting of 9 pages.

1.2 CONTRACTOR represents that it has the skills, experience, and knowledge necessary to perform under this Agreement and the COUNTY relies upon this representation. CONTRACTOR shall perform to the satisfaction of the COUNTY and in conformance to and consistent with the highest standards of firms/professionals in the same discipline in the State of California.

1.3 CONTRACTOR affirms that it is fully apprised of all of the work to be performed under this Agreement; and the CONTRACTOR agrees it can properly perform this work at the prices stated in Exhibit B. CONTRACTOR is not to perform services or provide products outside of the Agreement.

1.4 Acceptance by the COUNTY of the CONTRACTOR's performance under this Agreement does not operate as a release of CONTRACTOR's responsibility for full compliance with the terms of this Agreement.

2. Period of Performance

2.1 This Agreement shall be effective March 1, 2020 and continues in effect through January 31, 2025, unless terminated earlier. CONTRACTOR shall commence performance upon signature of this Agreement by both parties and shall diligently and continuously perform thereafter. The Riverside County Board of Supervisors is the only authority that may obligate the County for a non-cancelable multi-year agreement.

3. Compensation

3.1 The COUNTY shall pay the CONTRACTOR for services performed, products provided and expenses incurred in accordance with the terms of Exhibit A, Payment Provisions. Maximum payments by COUNTY to CONTRACTOR shall not exceed $150,000 (One Hundred Fifty Thousand Dollars) annually including all expenses. The COUNTY is not responsible for any fees or costs incurred above or beyond the contracted amount and shall have no obligation to purchase any specified amount of services or products. Unless otherwise specifically stated in Exhibit A, COUNTY shall not be responsible for payment of any of CONTRACTOR's expenses related to this Agreement.

3.2 No price increases will be permitted during the first year of this Agreement. All price decreases (for example, if CONTRACTOR offers lower prices to another governmental entity of similar asset and/or participant size and plan design within the County of Riverside) will automatically be extended to the COUNTY. The COUNTY requires written proof satisfactory to COUNTY of cost increases prior to any approved price adjustment. After the first year of the award, a minimum of 30-days advance notice in writing is required to be considered and approved by COUNTY. No retroactive price adjustments will be considered. Any price increases must be stated in a written amendment to this Agreement. The net dollar amount of profit will remain firm during the period of the Agreement. Annual increases shall not exceed the Consumer Price Index- All Consumers, All Items - Greater Los Angeles, Riverside and Orange County areas and be subject to satisfactory performance review by the COUNTY and approved (if needed) for budget funding by the Board of Supervisors.

3.3 CONTRACTOR shall be paid only in accordance with an invoice submitted to COUNTY by CONTRACTOR within fifteen (15) business days from the last day of each calendar month, and COUNTY shall pay the invoice within thirty (30) working days from the date of receipt of the invoice. Payment shall be made to CONTRACTOR only after services have been rendered or delivery of materials or products, and acceptance has been made by COUNTY. Prepare invoices in duplicate. For this Agreement, send the original and duplicate copies of invoices to:

Riverside County Human Resources Department
Retirement Division
4080 Lemon St.
Riverside, CA 92501

a) Each invoice shall contain a minimum of the following information: invoice number and date; remittance address; bill-to and ship-to addresses of ordering department/division; Agreement number (HRARC-91840-004-01/25); quantities; item descriptions, unit prices, extensions, sales/use tax if applicable, and an invoice total.
b) Invoices shall be rendered monthly in arrears.

3.4 The COUNTY obligation for payment of this Agreement beyond the current fiscal year end is contingent upon and limited by the availability of COUNTY funding from which payment can be made, and invoices shall be rendered "monthly" in arrears. In the State of California, Government agencies are not allowed to pay excess interest and late charges, per Government Codes, Section 926.10. No legal liability on the part of the COUNTY shall arise for payment beyond June 30 of each calendar year unless funds are made available for such payment. In the event that such funds are not forthcoming for any reason, COUNTY shall immediately

notify CONTRACTOR in writing; and this Agreement shall be deemed terminated, have no further force, and effect.

4. Alteration or Changes to the Agreement

4.1 The Board of Supervisors and the COUNTY Purchasing Agent and/or his/her designee are the only authorized COUNTY representatives who may at any time, by written order, alter this Agreement. If any such alteration causes an increase or decrease in the cost of, or the time required for the performance under this Agreement, an equitable adjustment shall be made in the Agreement price or delivery schedule, or both, and the Agreement shall be modified by written amendment accordingly.

4.2 Any claim by the CONTRACTOR for additional payment related to this Agreement shall be made in writing by the CONTRACTOR within 30 days of when the CONTRACTOR has or should have notice of any actual or claimed change in the work, which results in additional and unanticipated cost to the CONTRACTOR. If the COUNTY Purchasing Agent decides that the facts provide sufficient justification, may authorize additional payment to the CONTRACTOR pursuant to the claim. Nothing in this section shall excuse the CONTRACTOR from proceeding with performance of the Agreement even if there has been a change.

5. Termination

5.1. COUNTY may terminate this Agreement without cause upon 30 days written notice served upon the CONTRACTOR stating the extent and effective date of termination.

5.2 COUNTY may, upon five (5) days written notice terminate this Agreement for CONTRACTOR's default, if CONTRACTOR refuses or fails to comply with the terms of this Agreement or fails to make progress that may endanger performance and does not immediately cure such failure. In the event of such termination, the COUNTY may proceed with the work in any manner deemed proper by COUNTY.

5.3 After receipt of the notice of termination, CONTRACTOR shall:

(a) Stop all work under this Agreement on the date specified in the notice of termination; and

(b) Transfer to COUNTY and deliver in the manner as directed by COUNTY any materials, reports or other products, which, if the Agreement had been completed or continued, would have been required to be furnished to COUNTY.

5.4 After termination, COUNTY shall make payment only for CONTRACTOR's performance up to the date of termination in accordance with this Agreement.

5.5 CONTRACTOR's rights under this Agreement shall terminate (except for fees accrued prior to the date of termination) upon dishonesty or a willful or material breach of this Agreement by CONTRACTOR; or in the event of CONTRACTOR's unwillingness or inability for any reason whatsoever to perform the terms

of this Agreement. In such event, CONTRACTOR shall not be entitled to any further compensation under this Agreement.

5.6 If the Agreement is federally or State funded, CONTRACTOR cannot be debarred from the System for Award Management (SAM). CONTRACTOR must notify the COUNTY immediately of a debarment. CONTRACTOR to reference: System for Award Management (SAM) at https://www.sam.gov for Central Contractor Registry (CCR), Federal Agency Registration (Fedreg), Online Representations and Certifications Application, and Excluded Parties List System (EPLS)). Excluded Parties Listing System (EPLS) (http://www.epls.gov) (Executive Order 12549, 7 CFR Part 3017, 45 CFR Part 76, and 44 CFR Part 17). The System for Award Management (SAM) is the Official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA, and EPLS.

5.7 The rights and remedies of COUNTY provided in this section shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6. Ownership/Use of Contract Materials and Products

The CONTRACTOR agrees that all materials, reports or products in any form, including electronic, created by CONTRACTOR for which CONTRACTOR has been compensated by COUNTY pursuant to this Agreement shall be the sole property of the COUNTY. The material, reports or products may be used by the COUNTY for any purpose COUNTY deems to be appropriate, including, but not limit to, duplication and/or distribution within the COUNTY or to third parties. CONTRACTOR agrees not to release or circulate in whole or part such materials, reports, or products without prior written authorization of the COUNTY.

7. Conduct of Contractor

7.1 The CONTRACTOR covenants that it presently has no interest, including, but not limited to, other projects or contracts, and shall not acquire any such interest, direct or indirect, which would conflict in any manner or degree with CONTRACTOR's performance under this Agreement. The CONTRACTOR further covenants that no person or subcontractor having any such interest shall be employed or retained by CONTRACTOR under this Agreement. The CONTRACTOR agrees to inform the COUNTY of all the CONTRACTOR's interests, if any, which are or may be perceived as incompatible with the COUNTY's interests.

7.2 The CONTRACTOR shall not, under circumstances which could be interpreted as an attempt to influence the recipient in the conduct of his/her duties, accept any gratuity or special favor from individuals or firms with whom the CONTRACTOR is doing business or proposing to do business, in accomplishing the work under this Agreement.

7.3 The CONTRACTOR or its employees shall not offer gifts, gratuity, favors, and entertainment directly or indirectly to COUNTY employees.

8. Inspection of Service; Quality Control/Assurance

8.1 All performance (which includes services, workmanship, materials, supplies and equipment furnished or utilized in the performance of this Agreement) shall be subject to inspection and test by the COUNTY or other regulatory agencies at all times. The CONTRACTOR shall provide adequate cooperation to any inspector or other COUNTY representative to permit him/her to determine the CONTRACTOR's conformity with the terms of this Agreement. If any services performed or products provided by CONTRACTOR are not in conformance with the terms of this Agreement, the COUNTY shall have the right to require the CONTRACTOR to perform the services or provide the products in conformance with the terms of the Agreement at no additional cost to the COUNTY. When the services to be performed or the products to be provided are of such nature that the difference cannot be corrected; the COUNTY shall have the right to: (1) require the CONTRACTOR immediately to take all necessary steps to ensure future performance in conformity with the terms of the Agreement; and/or (2) reduce the Agreement price to reflect the reduced value of the services performed or products provided. The COUNTY may also terminate this Agreement for default and charge to CONTRACTOR any costs incurred by the COUNTY because of the CONTRACTOR's failure to perform.

8.2 CONTRACTOR shall establish adequate procedures for self-monitoring and quality control and assurance to ensure proper performance under this Agreement; and shall permit a COUNTY representative or other regulatory official to monitor, assess, or evaluate CONTRACTOR's performance under this Agreement at any time, upon reasonable notice to the CONTRACTOR.

9. Independent Contractor/Employment Eligibility

9.1 The CONTRACTOR is, for purposes relating to this Agreement, an independent contractor and shall not be deemed an employee of the COUNTY. It is expressly understood and agreed that the CONTRACTOR (including its employees, agents, and subcontractors) shall in no event be entitled to any benefits to which COUNTY employees are entitled, including but not limited to overtime, any retirement benefits, worker's compensation benefits, and injury leave or other leave benefits. There shall be no employer-employee relationship between the parties; and CONTRACTOR shall hold COUNTY harmless from any and all claims that may be made against COUNTY based upon any contention by a third party that an employer-employee relationship exists by reason of this Agreement. It is further understood and agreed by the parties that CONTRACTOR in the performance of this Agreement is subject to the control or direction of COUNTY merely as to the results to be accomplished and not as to the means and methods for accomplishing the results.

9.2 CONTRACTOR warrants that it shall make its best effort to comply with all federal and state statutes and regulations regarding the employment of aliens and others and to ensure that employees performing work under this Agreement meet the citizenship or alien status requirement set forth in federal statutes and

regulations. CONTRACTOR shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by federal or state statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 U.S.C. §1324 et seq., as they currently exist and as they may be hereafter amended. CONTRACTOR shall retain all such documentation for all covered employees, for the period prescribed by the law.

9.3 Ineligible Person shall be any individual or entity who: Is currently excluded, suspended, debarred or otherwise ineligible to participate in the federal health care programs; or has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the federal health care programs after a period of exclusion, suspension, debarment, or ineligibility.

9.4 CONTRACTOR shall screen prospective Covered Individuals prior to hire or engagement. CONTRACTOR shall not hire or engage any Ineligible Person to provide services directly relative to this Agreement. CONTRACTOR shall screen all current Covered Individuals within sixty (60) days of execution of this Agreement to ensure that they have not become Ineligible Persons unless CONTRACTOR has performed such screening on same Covered Individuals under a separate agreement with COUNTY within the past six (6) months. Covered Individuals shall be required to disclose to CONTRACTOR immediately any debarment, exclusion or other event that makes the Covered Individual an Ineligible Person. CONTRACTOR shall notify COUNTY within five (5) business days after it becomes aware if a Covered Individual providing services directly relative to this Agreement becomes debarred, excluded or otherwise becomes an Ineligible Person.

9.5 CONTRACTOR acknowledges that Ineligible Persons are precluded from providing federal and state funded health care services by contract with COUNTY in the event that they are currently sanctioned or excluded by a federal or state law enforcement regulatory or licensing agency. If CONTRACTOR becomes aware that a Covered Individual has become an Ineligible Person, CONTRACTOR shall remove such individual from responsibility for, or involvement with, COUNTY business operations related to this Agreement.

9.6 CONTRACTOR shall notify COUNTY within five (5) business days if a Covered Individual or entity is currently excluded, suspended or debarred, or is identified as such after being sanction screened. Such individual or entity shall be promptly removed from participating in any activity associated with this Agreement.

10. Subcontract for Work or Services

No contract shall be made by the CONTRACTOR with any other party for furnishing any of the work or services under this Agreement without the prior written approval of the COUNTY; but this provision shall not require the approval of contracts of employment between the CONTRACTOR and personnel assigned under this Agreement, or for parties named in the proposal and agreed to under this Agreement.

11. Disputes

11.1 The parties shall attempt to resolve any disputes amicably at the working level. If that is not successful, the dispute shall be referred to the senior management of the parties. Any dispute relating to this Agreement, which is not resolved by the parties, shall be decided by the COUNTY's Purchasing Department's Compliance Contract Officer who shall furnish the decision in writing. The decision of the COUNTY's Compliance Contract Officer shall be final and conclusive unless determined by a court of competent jurisdiction to have been fraudulent, capricious, arbitrary, or so grossly erroneous to imply bad faith. The CONTRACTOR shall proceed diligently with the performance of this Agreement pending the resolution of a dispute.

11.2 Prior to the filing of any legal action related to this Agreement, the parties shall be obligated to attend a mediation session in Riverside County before a neutral third party mediator. A second mediation session shall be required if the first session is not successful. The parties shall share the cost of the mediations.

12. Licensing and Permits

CONTRACTOR shall comply with all State or other licensing requirements. All licensing requirements shall be met at the time proposals are submitted to the COUNTY. CONTRACTOR warrants that it has all necessary permits, approvals, certificates, waivers and exemptions necessary for performance of this Agreement as required by the laws and regulations of the United States, the State of California, the County of Riverside and all other governmental agencies with jurisdiction, and shall maintain these throughout the term of this Agreement.

13. Use By Other Political Entities

The CONTRACTOR agrees to extend the same pricing, terms, and conditions as stated in this Agreement to each and every political entity, special district, and related non-profit entity in Riverside County. It is understood that other entities shall make purchases in their own name, make direct payment, and be liable directly to the CONTRACTOR; and COUNTY shall in no way be responsible to CONTRACTOR for other entities' purchases.

14. Non-Discrimination

CONTRACTOR shall not be discriminate in the provision of services, allocation of benefits, accommodation in facilities, or employment of personnel on the basis of ethnic group identification, race,

religious creed, color, national origin, ancestry, physical handicap, medical condition, marital status or sex in the performance of this Agreement; and, to the extent they shall be found to be applicable hereto, shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code 12900 et. seq), the Federal Civil Rights Act of 1964 (P.L. 88-352), the Americans with Disabilities Act of 1990 (42 U.S.C. S1210 et seq.) and all other applicable laws or regulations.

15. Records and Documents

CONTRACTOR shall make available, upon written request by any duly authorized Federal, State, or COUNTY agency, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the CONTRACTOR's costs related to this Agreement. All such books, documents and records shall be maintained by CONTRACTOR for at least five years following termination of this Agreement and be available for audit by the COUNTY. CONTRACTOR shall provide to the COUNTY reports and information related to this Agreement as requested by COUNTY.

16. Confidentiality

16.1 The CONTRACTOR shall not use for personal gain or make other improper use of privileged or confidential information which is acquired in connection with this Agreement. The term "privileged or confidential information" includes but is not limited to: unpublished or sensitive technological or scientific information; medical, personnel, or security records; anticipated material requirements or pricing/purchasing actions; COUNTY information or data which is not subject to public disclosure; COUNTY operational procedures; and knowledge of selection of contractors, subcontractors or suppliers in advance of official announcement.

16.2 The CONTRACTOR shall protect from unauthorized disclosure names and other identifying information concerning persons receiving services pursuant to this Agreement, except for general statistical information not identifying any person. The CONTRACTOR shall not use such information for any purpose other than carrying out the CONTRACTOR's obligations under this Agreement. The CONTRACTOR shall promptly transmit to the COUNTY all third party requests for disclosure of such information. The CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Agreement or authorized in advance in writing by the COUNTY, any such information to anyone other than the COUNTY. For purposes of this paragraph, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particulars assigned to the individual, such as finger or voice print or a photograph.

16.3 The CONTRACTOR is subject to and shall operate in compliance with all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191,

enacted August 21, 1996, and the related laws and regulations promulgated subsequent thereto. Please refer to Attachment 1 of this agreement.

17. Administration/Contract Liaison

The COUNTY Purchasing Agent, or designee, shall administer this Agreement on behalf of the COUNTY. The Purchasing Department is to serve as the liaison with CONTRACTOR in connection with this Agreement.

18. Notices

All correspondence and notices required or contemplated by this Agreement shall be delivered to the respective parties at the addresses set forth below and are deemed submitted two days after their deposit in the United States mail, postage prepaid:

COUNTY OF RIVERSIDE	**CONTRACTOR**
Human Resources Retirement Division	Gallagher Benefit Services, Inc.
4080 Lemon Street	906 West 2nd Ave., Suite 400
Riverside, CA 92501	Spokane, WA 99201
Attn: Stacey Beale	Attn:

19. Force Majeure

In case by reason of force majeure either party hereto shall be rendered unable wholly or in part to carry out its obligations under this Agreement, then except as otherwise expressly provided in this Agreement, if such party shall give notice and full particulars of such force majeure in writing to the other party within a reasonable time after occurrence of the event or cause relied on, the obligations of the party giving such notice (other than the obligations pertaining to Insurance, Section 22 herein, or Hold Harmless/Indemnification, Section 21 herein), so far as they are affected by such force majeure, shall be suspended during the continuance of the inability then claimed which shall include a reasonable time for the removal of the effect thereof, but for no longer period, and such party shall endeavor to remove or overcome such inability with all reasonable dispatch. The term "force majeure," as employed herein, shall mean any cause beyond the reasonable control of either party and shall include, but shall not be limited to, labor disputes or other industrial disturbances, systemic electrical, telecommunications or other utility failures, earthquakes, hurricanes, tornadoes or other acts of nature, embargoes, riots, acts or orders of government, acts of terrorism or war. The parties agree that this provision is not applicable to any administrative fees and other fees and expenses that are payable from participant accounts or assets of the Trust in accordance with the Plan Documents.

20. EDD Reporting Requirements

In order to comply with child support enforcement requirements of the State of California, the COUNTY may be required to submit a Report of Independent Contractor(s) form DE 542 to the Employment Development Department. The CONTRACTOR agrees to furnish the required data and certifications to the COUNTY within 10 days of notification of award of Agreement when required by the EDD. This data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders. Failure of the CONTRACTOR to timely submit the data and/or certificates required may result in the contract being awarded to another contractor. In the event a contract has been issued, failure of the CONTRACTOR to comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignments Orders and Notices of Assignment shall constitute a material breach of Agreement. If CONTRACTOR has any questions concerning this reporting requirement, please call (916) 657-0529. CONTRACTOR should also contact its local Employment Tax Customer Service Office listed in the telephone directory in the State Government section under "Employment Development Department" or access their Internet site at www.edd.ca.gov.

21. Hold Harmless/Indemnification

21.1 CONTRACTOR shall indemnify and hold harmless the County of Riverside, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (individually and collectively hereinafter referred to as Indemnitees) from any liability, action, claim or damage whatsoever, based or asserted upon any services of CONTRACTOR, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature. CONTRACTOR shall defend, at its sole expense, all costs, and fees including, but not limited, to attorney fees, cost of investigation, defense and settlements or awards, the Indemnitees in any claim or action based upon such alleged acts or omissions.

21.2 With respect to any action or claim subject to indemnification herein by CONTRACTOR, CONTRACTOR shall, at their sole cost, have the right to use counsel of their own choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of COUNTY; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes CONTRACTOR'S indemnification to Indemnitees as set forth herein.

21.3 CONTRACTOR'S obligation hereunder shall be satisfied when CONTRACTOR has provided to COUNTY the appropriate form of dismissal relieving COUNTY from any liability for the action or claim involved.

21.4 The specified insurance limits required in this Agreement shall in no way limit or circumscribe CONTRACTOR'S obligations to indemnify and hold harmless the Indemnitees herein from third party claims.

22. Insurance

22.1 Without limiting or diminishing the CONTRACTOR'S obligation to indemnify or hold the COUNTY harmless, CONTRACTOR shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Agreement. As respects to the insurance section only, the COUNTY herein refers to the County of Riverside, its Agencies, Districts, Special Districts, and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents, or representatives as Additional Insureds.

A. Workers' Compensation:

If the CONTRACTOR has employees as defined by the State of California, the CONTRACTOR shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside.

B. Commercial General Liability:

Commercial General Liability insurance coverage, including but not limited to, premises liability, unmodified contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage, covering claims which may arise from or out of CONTRACTOR'S performance of its obligations hereunder. Policy shall name the COUNTY as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

C. Professional Liability Contractor shall maintain Professional Liability Insurance providing coverage for the Contractor's performance of work included within this Agreement, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Contractor's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this Agreement and CONTRACTOR shall purchase at his/her sole expense either 1) an Extended Reporting Endorsement (also, known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that CONTRACTOR has Maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2), or 3) will continue as long as the law allows.

D. General Insurance Provisions - All lines:

1) Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California and have an A M BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by the County Risk Manager. If the County's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.

2) The CONTRACTOR must declare its insurance self-insured retention for each coverage required herein. If any such self-insured retention exceeds $5,000,000 per occurrence each such retention shall have the prior written consent of the County Risk Manager before the commencement of operations under this Agreement. Upon notification of self-insured retention unacceptable to the COUNTY, and at the election of the Country's Risk Manager, CONTRACTOR'S carriers shall either; 1) reduce or eliminate such self-insured retention as respects this Agreement with the COUNTY, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3) CONTRACTOR shall cause CONTRACTOR'S insurance carrier(s) to furnish the County of Riverside with a properly executed original Certificate(s) of Insurance and certified original copies of Endorsements effecting coverage as required herein. Further, CONTRACTOR shall replace any cancelled or non-renewed policy with no coverage gap and provide a new Certificate of Insurance to the County of Riverside. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. CONTRACTOR shall not commence operations until the COUNTY has been furnished original Certificate (s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier shall sign the original endorsements for each policy and the Certificate of Insurance.

4) It is understood and agreed to by the parties hereto that the CONTRACTOR'S commercial general liability insurance shall be construed as primary insurance, and the COUNTY'S insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

5) If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work; or, the term of this Agreement, including any extensions thereof, exceeds five (5) years; the COUNTY reserves the right to adjust the types of insurance and the monetary limits of liability required under this Agreement, if in

the County Risk Manager's reasonable judgment, the amount or type of insurance carried by the CONTRACTOR has become inadequate.

6) CONTRACTOR shall pass down the insurance obligations contained herein to all tiers of subcontractors working under this Agreement; provided that subcontractors of the CONTRACTOR shall be permitted to maintain worker's compensation coverage statutorily required for states in which their employees reside and work with limits that are commercially reasonable for their applicable industry and services provided.

7) The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the COUNTY.

8) CONTRACTOR agrees to notify COUNTY of any claim by a third party or any incident or event that may give rise to a claim arising from the performance of this Agreement.

23. General

23.1 CONTRACTOR shall not delegate or assign any interest in this Agreement, whether by operation of law or otherwise, without the prior written consent of COUNTY. Any attempt to delegate or assign any interest herein shall be deemed void and of no force or effect.

23.2 Any waiver by COUNTY of any breach of any one or more of the terms of this Agreement shall not be construed to be a waiver of any subsequent or other breach of the same or of any other term of this Agreement. Failure on the part of COUNTY to require exact, full, and complete compliance with any terms of this Agreement shall not be construed as in any manner changing the terms or preventing COUNTY from enforcement of the terms of this Agreement.

23.3 In the event the CONTRACTOR receives payment under this Agreement, which is later disallowed by COUNTY for nonconformance with the terms of the Agreement, the CONTRACTOR shall promptly refund the disallowed amount to the COUNTY on request; or at its option the COUNTY may offset the amount disallowed from any payment due to the CONTRACTOR.

23.4 CONTRACTOR shall not provide partial delivery or shipment of services or products unless specifically stated in the Agreement.

23.5 CONTRACTOR shall not provide any services or products subject to any chattel mortgage or under a conditional sales contract or other agreement by which an interest is retained by a third party. The CONTRACTOR warrants that it has good title to all materials or products used by CONTRACTOR or provided to COUNTY pursuant to this Agreement, free from all liens, claims, or encumbrances.

23.6 Nothing in this Agreement shall prohibit the COUNTY from acquiring the same type or equivalent equipment, products, materials or services from other sources, when deemed by the COUNTY to be

in its best interest. The COUNTY reserves the right to purchase more or less than the quantities specified in this Agreement.

23.7 The COUNTY agrees to cooperate with the CONTRACTOR in the CONTRACTOR's performance under this Agreement, including, if stated in the Agreement, providing the CONTRACTOR with reasonable facilities and timely access to COUNTY data, information, and personnel.

23.8 CONTRACTOR shall comply with all applicable Federal, State and local laws and regulations. CONTRACTOR will comply with all applicable COUNTY policies and procedures. In the event that there is a conflict between the various laws or regulations that may apply, the CONTRACTOR shall comply with the more restrictive law or regulation.

23.9 CONTRACTOR shall comply with all air pollution control, water pollution, safety and health ordinances, statutes, or regulations, which apply to performance under this Agreement.

23.10 CONTRACTOR shall comply with all requirements of the Occupational Safety and Health Administration (OSHA) standards and codes as set forth by the U.S. Department of Labor and the State of California (Cal/OSHA).

23.11 This Agreement and the undertaking sherein for the benefit of the parties shall be governed by the laws of the State of California and the United States of America, and regulations promulgated thereato. Any provision required to be in this Agreement by any applicable federal or state law, and regulations thereto shall bind the parties hereto, wehther or not expressly provided in this Agreement. All actions and proceedings arising in connection with this Agreement and the undertakings herein shall be tried and litigated exclusively in the State and federal (if permitted by law and a Party elects to file an action in federal court) courts in the County of Riverside, State of California.

23.12 This Agreement, including any attachments or exhibits, constitutes the entire Agreement of the parties with respect to its subject matter and supersedes all prior and contemporaneous representations, proposals, discussions and communications, whether oral or in writing. This Agreement may be changed or modified only by a written amendment signed by authorized representatives of both parties.

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to excute this Agreement. Each party certifies that the individuals signing below has the authority to execute this Agreement on behalf of such party and may legally bind such party to the terms and conditions of the Agreement, including any attachments hereto.

COUNTY OF RIVERSIDE, a political subdivision of the State of California

By: _____
~~Kevin Jeffries~~, Chairman
Board of Supervisors V. MANUEL PEREZ

Dated: FEB 11 2020

ATTEST:
Kecia Harper
Clerk of the Board

By: _____
Deputy

APPROVED AS TO FORM:
Gregory P. Priamos
County Counsel

By: _____
SYNTHIA M. GUNZEL
Chief Deputy County Counsel

GALLAGHER BENEFIT SERVICES, INC.

By: _____
Charlie Isaacs
Area President

Dated: 1-21-20

Exhibit A

Payment Provisions

1. Administrative Fees
   1.1. Monthly Per Participant Account Fee:
   This amount will be deducted once per calendar month from participant accounts unless the COUNTY elects to pay this fee:
   1.1.1. $1.25 claims-eligible
   1.1.2. $0.00 non-claims eligible
   1.2. Annualized Asset Fee:
   This fee will be prorated and deducted from participant accounts on a daily basis at a rate of 1/365 of the listed annualized fee unless the COUNTY elects to pay this fee:
   1.2.1. 0.20%
2. Plan Sponsor Fees
   2.1. Included
3. Implementation Fees
   3.1. Included
4. Debit Card Fees
   4.1. Included
5. Small or Inactive Account Fees
   5.1. Included
6. Participant Transaction Fees
   6.1. Included
7. Regulatory Fees
   7.1. The HealthInvest HRA Plan is required to assess the Annual Patient-Centered Outcomes Research Institute (PCORI) fee. The PCORI fee is an annual per-participant fee accessed by the federal government as required under federal healthcare reform regulations. The PCORI fee increases each year (through plan years beginning in 2019) based on increases in the projected per capita amount of national health expenditures.
   For non-ERISA Plans that are subject to this fee, such as the County of Riverside's VEBA HSP Plan, a prorated portion of this annual fee will be deducted once every three months from the account of any participant who is eligible to file claims.

8. Fees for Additional Services

   8.1. If the COUNTY requests additional, extraordinary services outside the basic scope of the Agreement, the CONTRACTOR shall propose additional fees based on each request.

9. Other Administrative Fees (not included in the above, e.g., travel, printing, and postage, etc.):

   9.1. None

Exhibit B
HIPAA Business Associate Agreement
Addendum to Contract
Between the County of Riverside and Gallagher Benefit Services, Inc.

This HIPAA Business Associate Agreement (the "Addendum") supplements, and is made part of the Professional Services Agreement (the "Underlying Agreement") between the County of Riverside ("County") and Gallagher Benefit Services, Inc. ("Contractor") and shall be effective as of the date the Underlying Agreement is approved by both Parties (the "Effective Date").

RECITALS

WHEREAS, County and Contractor entered into the Underlying Agreement pursuant to which the Contractor provides services to County, and in conjunction with the provision of such services certain protected health information ("PHI") and/or certain electronic protected health information ("ePHI") may be created by or made available to Contractor for the purposes of carrying out its obligations under the Underlying Agreement; and,

WHEREAS, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191 enacted August 21, 1996, and the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time, are applicable to the protection of any use or disclosure of PHI and/or ePHI pursuant to the Underlying Agreement; and,

WHEREAS, County is a covered entity, as defined in the Privacy Rule; and,

WHEREAS, to the extent County discloses PHI and/or ePHI to Contractor or Contractor creates, receives, maintains, transmits, or has access to PHI and/or ePHI of County, Contractor is a business associate, as defined in the Privacy Rule; and,

WHEREAS, pursuant to 42 USC §17931 and §17934, certain provisions of the Security Rule and Privacy Rule apply to a business associate of a covered entity in the same manner that they apply to the covered entity, the additional security and privacy requirements of HITECH are applicable to business associates and must be incorporated into the business associate agreement, and a business associate is liable for civil and criminal penalties for failure to comply with these security and/or privacy provisions; and,

WHEREAS, the parties mutually agree that any use or disclosure of PHI and/or ePHI must be in compliance with the Privacy Rule, Security Rule, HIPAA, HITECH and any other applicable law; and,

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply to Contractor as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Contractor during the course of performing functions, services and activities on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HITECH, HIPAA, Security Rule and/or Privacy Rule, as may be amended from time to time.

   A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402.

      (1) Except as provided below in Paragraph (2) of this definition, acquisition, access, use, or disclosure of PHI in a manner not permitted by subpart E of the Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following four factors:

         (a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

         (b) The unauthorized person who used the PHI or to whom the disclosure was made;

         (c) Whether the PHI was actually acquired or viewed; and

(d) The extent to which the risk to the PHI has been mitigated.

(2) Breach excludes:

(a) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of the Privacy Rule.

(b) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by subpart E of the Privacy Rule.

(c) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

B. "Business associate" has the meaning given such term in 45 CFR §164.501, including but not limited to a subcontractor that creates, receives, maintains, transmits or accesses PHI on behalf of the business associate.

C. "Data aggregation" has the meaning given such term in 45 CFR §164.501.

D. "Designated record set" as defined in 45 CFR §164.501 means a group of records maintained by or for a covered entity that may include: the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or, used, in whole or in part, by or for the covered entity to make decisions about individuals.

E. "Electronic protected health information" ("ePHI") as defined in 45 CFR §160.103 means protected health information transmitted by or maintained in electronic media.

F. "Electronic health record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given such term in 42 USC §17921(5).

G. "Health care operations" has the meaning given such term in 45 CFR §164.501.

H. "Individual" as defined in 45 CFR §160.103 means the person who is the subject of protected health information.

I. "Person" as defined in 45 CFR §160.103 means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

J. "Privacy Rule" means the HIPAA regulations codified at 45 CFR Parts 160 and 164, Subparts A and E.

K. "Protected health information" ("PHI") has the meaning given such term in 45 CFR §160.103, which includes ePHI.

L. "Required by law" has the meaning given such term in 45 CFR §164.103.

M. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS").

N. "Security incident" as defined in 45 CFR §164.304 means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. "Security Rule" means the HIPAA Regulations codified at 45 CFR Parts 160 and 164, Subparts A and C.

P. "Subcontractor" as defined in 45 CFR §160.103 means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

Q. "Unsecured protected health information" and "unsecured PHI" as defined in 45 CFR §164.402 means PHI not rendered unusable, unreadable, or indecipherable to unauthorized persons through use of a technology or methodology specified by the Secretary in the guidance issued under 42 USC §17932(h)(2).

2. **Scope of Use and Disclosure by Contractor of County's PHI and/or ePHI.**

A. Except as otherwise provided in this Addendum, Contractor may use, disclose, or access PHI and/or ePHI as necessary to perform any and all obligations of Contractor under the Underlying Agreement or to perform functions, activities or services for, or on behalf of, County as specified in this Addendum, if such use or disclosure does not violate HIPAA, HITECH, the Privacy Rule and/or Security Rule.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, in accordance with 45 CFR §164.504(e)(2), Contractor may:

1) Use PHI and/or ePHI if necessary for Contractor's proper management and administration and to carry out its legal responsibilities; and,

2) Disclose PHI and/or ePHI for the purpose of Contractor's proper management and administration or to carry out its legal responsibilities, only if:

a) The disclosure is required by law; or,

b) Contractor obtains reasonable assurances, in writing, from the person to whom Contractor will disclose such PHI and/or ePHI that the person will:

i. Hold such PHI and/or ePHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person, or as required by law; and,

ii. Notify County of any instances of which it becomes aware in which the confidentiality of the information has been breached; and,

3) Use PHI to provide data aggregation services relating to the health care operations of County pursuant to the Underlying Agreement or as requested by County; and,

4) De-identify all PHI and/or ePHI of County received by Contractor under this Addendum provided that the de-identification conforms to the requirements of the Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

C. Notwithstanding the foregoing, in any instance where applicable state and/or federal laws and/or regulations are more stringent in their requirements than the provisions of HIPAA, including, but not limited to, prohibiting disclosure of mental health and/or substance abuse records, the applicable state and/or federal laws and/or regulations shall control the disclosure of records.

3. **Prohibited Uses and Disclosures.**

A. Contractor may neither use, disclose, nor access PHI and/or ePHI in a manner not authorized by the Underlying Agreement or this Addendum without patient authorization or de-identification of the PHI and/or ePHI and as authorized in writing from County.

B. Contractor may neither use, disclose, nor access PHI and/or ePHI it receives from County or from another business associate of County, except as permitted or required by this Addendum, or as required by law.

C. Contractor agrees not to make any disclosure of PHI and/or ePHI that County would be prohibited from making.

D. Contractor shall not use or disclose PHI for any purpose prohibited by the Privacy Rule, Security Rule, HIPAA and/or HITECH, including, but not limited to 42 USC §17935 and §17936. Contractor agrees:

1) Not to use or disclose PHI for fundraising , unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.514(f) or 45 CFR §164.508;

2) Not to use or disclose PHI for marketing, as defined in 45 CFR §164.501, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.508(a)(3);

3) Not to disclose PHI, except as otherwise required by law, to a health plan for purposes of carrying out payment or health care operations, if the individual has requested this restriction pursuant to 42 USC §17935(a) and 45 CFR §164.522, and has paid out of pocket in full for the health care item or service to which the PHI solely relates; and,

4) Not to receive, directly or indirectly, remuneration in exchange for PHI, or engage in any act that would constitute a sale of PHI, as defined in 45 CFR §164.502(a)(5)(ii), unless permitted by the Underlying Agreement and in compliance with the requirements of a valid authorization under 45 CFR §164.508(a)(4). This prohibition shall not apply to payment by County to Contractor for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

A. County agrees to make its best efforts to notify Contractor promptly in writing of any restrictions on the use or disclosure of PHI and/or ePHI agreed to by County that may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

B. County agrees to make its best efforts to promptly notify Contractor in writing of any changes in, or revocation of, permission by any individual to use or disclose PHI and/or ePHI, if such changes or revocation may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

C. County agrees to make its best efforts to promptly notify Contractor in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or ePHI.

D. County agrees not to request Contractor to use or disclose PHI and/or ePHI in any manner that would not be permissible under HITECH, HIPAA, the Privacy Rule, and/or Security Rule.

E. County agrees to obtain any authorizations necessary for the use or disclosure of PHI and/or ePHI, so that Contractor can perform its obligations under this Addendum and/or Underlying Agreement.

5. **Obligations of Contractor.** In connection with the use or disclosure of PHI and/or ePHI, Contractor agrees to:

A. Use or disclose PHI only if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e). Contractor shall also comply with the additional privacy requirements that are applicable to covered entities in HITECH, as may be amended from time to time.

B. Not use or further disclose PHI and/or ePHI other than as permitted or required by this Addendum or as required by law. Contractor shall promptly notify County if Contractor is required by law to disclose PHI and/or ePHI.

C. Use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

D. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI and/or ePHI by Contractor in violation of this Addendum.

E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or Security Rule of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410.

F. In accordance with 45 CFR §164.502(e)(1)(ii), require that any subcontractors that create, receive, maintain, transmit or access PHI on behalf of the Contractor agree through contract to the same restrictions and conditions that apply to Contractor with respect to such PHI and/or ePHI, including the restrictions and conditions pursuant to this Addendum.

G. Make available to County or the Secretary, in the time and manner designated by County or Secretary, Contractor's internal practices, books and records relating to the use, disclosure and privacy protection of PHI received from County, or created or received by Contractor on behalf of County, for purposes of determining, investigating or auditing Contractor's and/or County's compliance with the Privacy Rule.

H. Request, use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the request, use or disclosure in accordance with 42 USC §17935(b) and 45 CFR §164.502(b)(1).

I. Comply with requirements of satisfactory assurances under 45 CFR §164.512 relating to notice or qualified protective order in response to a third party's subpoena, discovery request, or other lawful process for the disclosure of PHI, which Contractor shall promptly notify County upon Contractor's receipt of such request from a third party.

J. Not require an individual to provide patient authorization for use or disclosure of PHI as a condition for treatment, payment, enrollment in any health plan (including the health plan administered by County), or eligibility of benefits, unless otherwise excepted under 45 CFR §164.508(b)(4) and authorized in writing by County.

K. Use appropriate administrative, technical and physical safeguards to prevent inappropriate use, disclosure, or access of PHI and/or ePHI.

L. Obtain and maintain knowledge of applicable laws and regulations related to HIPAA and HITECH, as may be amended from time to time.

M. Comply with the requirements of the Privacy Rule that apply to the County to the extent Contractor is to carry out County's obligations under the Privacy Rule.

N. Take reasonable steps to cure or end any pattern of activity or practice of its subcontractor of which Contractor becomes aware that constitute a material breach or violation of the subcontractor's obligations under the business associate contract with Contractor, and if such steps are unsuccessful, Contractor agrees to terminate its contract with the subcontractor if feasible.

6. **Access to PHI, Amendment and Disclosure Accounting.** Contractor agrees to:

A. **Access to PHI, including ePHI.** Provide access to PHI, including ePHI if maintained electronically, in a designated record set to County or an individual as directed by County, within five (5) days of request from County, to satisfy the requirements of 45 CFR §164.524.

B. **Amendment of PHI.** Make PHI available for amendment and incorporate amendments to PHI in a designated record set County directs or agrees to at the request of an individual, within fifteen (15) days of receiving a written request from County, in accordance with 45 CFR §164.526.

C. **Accounting of disclosures of PHI and electronic health record.** Assist County to fulfill its obligations to provide accounting of disclosures of PHI under 45 CFR §164.528 and, where applicable, electronic health records under 42 USC §17935(c) if Contractor uses or maintains electronic health records. Contractor shall:

1) Document such disclosures of PHI and/or electronic health records, and information related to such disclosures, as would be required for County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record in accordance with 45 CFR §164.528.

2) Within fifteen (15) days of receiving a written request from County, provide to County or any individual as directed by County information collected in accordance with this section to permit County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record.

3) Make available for County information required by this Section 6.C for six (6) years preceding the individual's request for accounting of disclosures of PHI, and for three (3) years preceding the individual's request for accounting of disclosures of electronic health record.

7. **Security of ePHI.** In the event County discloses ePHI to Contractor or Contractor needs to create, receive, maintain, transmit or have access to County ePHI, in accordance with 42 USC §17931 and 45 CFR §164.314(a)(2)(i), and §164.306, Contractor shall:

   1. Comply with the applicable requirements of the Security Rule, and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that Contractor creates, receives, maintains, or transmits on behalf of County in accordance with 45 CFR §164.308, §164.310, and §164.312;

   2. Comply with each of the requirements of 45 CFR §164.316 relating to the implementation of policies, procedures and documentation requirements with respect to ePHI;

   3. Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;

   4. Protect against any reasonably anticipated uses or disclosures of ePHI that are not permitted or required under the Privacy Rule;

   5. Ensure compliance with the Security Rule by Contractor's workforce;

   6. In accordance with 45 CFR §164.308(b)(2), require that any subcontractors that create, receive, maintain, transmit, or access ePHI on behalf of Contractor agree through contract to the same restrictions and requirements contained in this Addendum and comply with the applicable requirements of the Security Rule;

   7. Report to County any security incident of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410; and,

   8. Comply with any additional security requirements that are applicable to covered entities in Title 42 (Public Health and Welfare) of the United States Code, as may be amended from time to time, including but not limited to HITECH.

8. **Breach of Unsecured PHI.** In the case of breach of unsecured PHI, Contractor shall comply with the applicable provisions of 42 USC §17932 and 45 CFR Part 164, Subpart D, including but not limited to 45 CFR §164.410.

   A. **Discovery and notification.** Following the discovery of a breach of unsecured PHI, Contractor shall notify County in writing of such breach without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, except as provided in 45 CFR §164.412.

      1) **Breaches treated as discovered.** A breach is treated as discovered by Contractor as of the first day on which such breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor, which includes any person, other than the person committing the breach, who is an employee, officer, or other agent of Contractor (determined in accordance with the federal common law of agency).

      2) **Content of notification.** The written notification to County relating to breach of unsecured PHI shall include, to the extent possible, the following information if known (or can be reasonably obtained) by Contractor:

         a) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed during the breach;

         b) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

         c) A description of the types of unsecured PHI involved in the breach, such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved;

         d) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

e) A brief description of what Contractor is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and,

f) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

B. **Cooperation.** With respect to any breach of unsecured PHI reported by Contractor, Contractor shall cooperate with County and shall provide County with any information requested by County to enable County to fulfill in a timely manner its own reporting and notification obligations, including but not limited to providing notice to individuals, prominent media outlets and the Secretary in accordance with 42 USC §17932 and 45 CFR §164.404, §164.406 and §164.408.

C. **Breach log.** To the extent breach of unsecured PHI involves less than 500 individuals, Contractor shall maintain a log or other documentation of such breaches and provide such log or other documentation on an annual basis to County not later than fifteen (15) days after the end of each calendar year for submission to the Secretary.

D. **Delay of notification authorized by law enforcement.** If Contractor delays notification of breach of unsecured PHI pursuant to a law enforcement official's statement that required notification, notice or posting would impede a criminal investigation or cause damage to national security, Contractor shall maintain documentation sufficient to demonstrate its compliance with the requirements of 45 CFR §164.412.

E. **Payment of costs.** With respect to any breach of unsecured PHI caused solely by the Contractor's failure to comply with one or more of its obligations under this Addendum and/or the provisions of HITECH, HIPAA, the Privacy Rule or the Security Rule, Contractor agrees to pay any and all costs associated with providing all legally required notifications to individuals, media outlets, and the Secretary. This provision shall not be construed to limit or diminish Contractor's obligations to indemnify, defend and hold harmless County under Section 9 of this Addendum.

F. **Documentation.** Pursuant to 45 CFR §164.414(b), in the event Contractor's use or disclosure of PHI and/or ePHI violates the Privacy Rule, Contractor shall maintain documentation sufficient to demonstrate that all notifications were made by Contractor as required by 45 CFR Part 164, Subpart D, or that such use or disclosure did not constitute a breach, including Contractor's completed risk assessment and investigation documentation.

G. **Additional State Reporting Requirements.** The parties agree that this Section 8.G applies only if and/or when County, in its capacity as a licensed clinic, health facility, home health agency, or hospice, is required to report unlawful or unauthorized access, use, or disclosure of medical information under the more stringent requirements of California Health & Safety Code §1280.15. For purposes of this Section 8.G, "unauthorized" has the meaning given such term in California Health & Safety Code §1280.15(j)(2).

1) Contractor agrees to assist County to fulfill its reporting obligations to affected patients and to the California Department of Public Health ("CDPH") in a timely manner under the California Health & Safety Code §1280.15.

2) Contractor agrees to report to County any unlawful or unauthorized access, use, or disclosure of patient's medical information without unreasonable delay and no later than two (2) business days after Contractor detects such incident. Contractor further agrees such report shall be made in writing, and shall include substantially the same types of information listed above in Section 8.A.2 (Content of Notification) as applicable to the unlawful or unauthorized access, use, or disclosure as defined above in this section, understanding and acknowledging that the term "breach" as used in Section 8.A.2 does not apply to California Health & Safety Code §1280.15.

9. **Hold Harmless/Indemnification.**

A. Contractor agrees to indemnify and hold harmless County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Contractor, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Addendum, including but not limited to property damage, bodily injury, death, or any other element of any kind or nature whatsoever arising from the performance of Contractor, its officers, agents, employees, subcontractors, agents or representatives from this Addendum. Contractor shall defend, at its sole expense, all costs and fees, including but not limited to attorney fees, cost of

investigation, defense and settlements or awards, of County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents or representatives in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by Contractor, Contractor shall, at their sole cost, have the right to use counsel of their choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Contractor's indemnification to County as set forth herein. Contractor's obligation to defend, indemnify and hold harmless County shall be subject to County having given Contractor written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Contractor's expense, for the defense or settlement thereof. Contractor's obligation hereunder shall be satisfied when Contractor has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Addendum shall in no way limit or circumscribe Contractor's obligations to indemnify and hold harmless County herein from third party claims arising from issues of this Addendum.

D. In the event there is conflict between this clause and California Civil Code §2782, this clause shall be interpreted to comply with Civil Code §2782. Such interpretation shall not relieve the Contractor from indemnifying County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Addendum, this indemnification shall only apply to the subject issues included within this Addendum.

10. **Term.** This Addendum shall commence upon the Effective Date and shall terminate when all PHI and/or ePHI provided by County to Contractor, or created or received by Contractor on behalf of County, is destroyed or returned to County, or, if it is infeasible to return or destroy PHI and/ePHI, protections are extended to such information, in accordance with section 11.B of this Addendum.

11. **Termination.**

A. **Termination for Breach of Contract.** A breach of any provision of this Addendum by either party shall constitute a material breach of the Underlying Agreement and will provide grounds for terminating this Addendum and the Underlying Agreement with or without an opportunity to cure the breach, notwithstanding any provision in the Underlying Agreement to the contrary. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

1) Terminate the Underlying Agreement and this Addendum, effective immediately, if the other party breaches a material provision of this Addendum.

2) Provide the other party with an opportunity to cure the alleged material breach and in the event the other party fails to cure the breach to the satisfaction of the non-breaching party in a timely manner, the non-breaching party has the right to immediately terminate the Underlying Agreement and this Addendum.

3) If termination of the Underlying Agreement is not feasible, the breaching party, upon the request of the non-breaching party, shall implement, at its own expense, a plan to cure the breach and report regularly on its compliance with such plan to the non-breaching party.

B. **Effect of Termination.**

1) Upon termination of this Addendum, for any reason, Contractor shall return or, if agreed to in writing by County, destroy all PHI and/or ePHI received from County, or created or received by the Contractor on behalf of County, and, in the event of destruction, Contractor shall certify such destruction, in writing, to County. This provision shall apply to all PHI and/or ePHI which are in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of PHI and/or ePHI, except as provided below in paragraph (2) of this section.

2) In the event that Contractor determines that returning or destroying the PHI and/or ePHI is not feasible, Contractor shall provide written notification to County of the conditions that make such return or destruction not feasible. Upon

determination by Contractor that return or destruction of PHI and/or ePHI is not feasible, Contractor shall extend the protections of this Addendum to such PHI and/or ePHI and limit further uses and disclosures of such PHI and/or ePHI to those purposes which make the return or destruction not feasible, for so long as Contractor maintains such PHI and/or ePHI.

12. **General Provisions.**

A. **Retention Period.** Whenever Contractor is required to document or maintain documentation pursuant to the terms of this Addendum, Contractor shall retain such documentation for 6 years from the date of its creation or as otherwise prescribed by law, whichever is later.

B. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for County to comply with HITECH, the Privacy Rule, Security Rule, and HIPAA generally.

C. **Survival.** The obligations of Contractor under Sections 3, 5, 6, 7, 8, 9, 11.B and 12.A of this Addendum shall survive the termination or expiration of this Addendum.

D. **Regulatory and Statutory References.** A reference in this Addendum to a section in HITECH, HIPAA, the Privacy Rule and/or Security Rule means the section(s) as in effect or as amended.

E. **Conflicts.** The provisions of this Addendum shall prevail over any provisions in the Underlying Agreement that conflict or appear inconsistent with any provision in this Addendum.

F. **Interpretation of Addendum.**

1) This Addendum shall be construed to be part of the Underlying Agreement as one document. The purpose is to supplement the Underlying Agreement to include the requirements of the Privacy Rule, Security Rule, HIPAA and HITECH.
2) Any ambiguity between this Addendum and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, Security Rule, HIPAA and HITECH generally.

G. **Notices to County.** All notifications required to be given by Contractor to County pursuant to the terms of this Addendum shall be made in writing and delivered to the County both by fax and to both of the addresses listed below by either registered or certified mail return receipt requested or guaranteed overnight mail with tracing capability, or at such other address as County may hereafter designate. All notices to County provided by Contractor pursuant to this Section shall be deemed given or made when received by County.

County HIPAA Privacy Officer:	HIPAA Privacy Manager
County HIPAA Privacy Officer Address:	26520 Cactus Avenue, Moreno Valley, CA 92555
County HIPAA Privacy Officer Phone Number:	(951) 486-6471

Attachment B

MASTER TRUST ADOPTION AGREEMENT
FOR THE HEALTHINVEST HRA MASTER TRUST

The Master Trust Adoption Agreement by, and among Washington Trust Bank ("Master Trustee"), Gallagher Benefit Services, Inc. ("HRA Service Manager"), and the County of Riverside ("Plan Sponsor") effective March 1, 2020.

FEB 11 2020 3.18

MASTER TRUST ADOPTION AGREEMENT
FOR THE
HEALTHINVEST HRA MASTER TRUST

THIS MASTER TRUST ADOPTION AGREEMENT, by and among Washington Trust Bank, a trust bank chartered under the laws of the State of Washington ("Master Trustee"), Gallagher Benefit Services, Inc. ("Gallagher"), a Delaware corporation, in its capacity as the HRA Service Manager under the HealthInvest HRA Plan Documents (the "HRA Service Manager"), and the County of Riverside ("Plan Sponsor"), and the Participating Trust Signatory identified on the signature page hereto is effective as of the Effective Date set forth on the signature page hereto.

W I T N E S S E T H:

WHEREAS, the Plan Sponsor desires to utilize Gallagher's proprietary HealthInvest HRA Plan Documents and the services of Gallagher as the HRA Service Manager for one or more of the Plan Sponsor's health reimbursement arrangement (HRA) plans (each HRA plan individually and collectively, an "HRA Plan" or "Plan") established or to be established for the benefit of employees eligible to participate in the Plans;

WHEREAS, pursuant to a Plan Adoption Agreement between the Plan Sponsor and Gallagher, the Plan Sponsor has entered into a relationship with Gallagher whereby Gallagher provides nondiscretionary and ministerial administration support services as the HRA Service Manager of the HRA Plan by utilizing Gallagher's proprietary Plan Documents;

WHEREAS, the Plan Sponsor, as Administrator, administers the HRA Plan with the assistance of the HRA Service Manager at the direction of the Administrator; and

WHEREAS, pursuant to a trust document attached hereto as Exhibit C, the Plan Sponsor has established a trust (the "adopting trust") to fund contributions to the Plan to be held on behalf of the employees participating in the Plan and administered in accordance with the Plan Documents; and

WHEREAS, the Plan Sponsor and the Participating Trust Signatory described on the signature page hereto desire for the Plan Sponsor Trust to adopt and become a "Participating Trust" under that certain Master Trust established by the Master Trustee pursuant to the Agreement and Declaration of Master Trust attached hereto as Exhibit B (the "Master Trust");

WHEREAS, the Plan Sponsor and Participating Trust Signatory further desire to appoint the Master Trustee as a custodian, transfer agent, and nondiscretionary, directed trustee under the Master Trust to the extent that assets of the Participating Trust are held by the Master Trustee from time to time on behalf of the Participating Trust in connection with the administration of the HRA Plan;

WHEREAS, the Participating Trust Signatory and the Plan Sponsor further desire to authorize the use of the Master Trust to make, file, or report information on behalf of the HRA

Plans, as provided in the Plan Documents and as otherwise directed by the HRA Service Manager or the Administrators of the HRA Plans; and

WHEREAS, the Master Trustee and HRA Service Manager accept the primary trust as a Participating Trust in the Master Trust.

NOW, THEREFORE, the parties hereby represent and agree as follows:

1. Definitions and Terms Incorporated by Reference; Conflicting Provisions.

(a) The term "Plan Documents" is defined in each HealthInvest Plan Coverage Document, which includes this Master Trust Adoption Agreement, the Master Trust, the Participating Trust, the Plan Adoption Agreement executed by the Plan Sponsor to adopt the Plan, each HealthInvest HRA plan document defining the terms and conditions for coverage under the Plan, and with respect to each employee participating in the Plan, the enrollment file, which contains information required to enroll the employee in the Plan.

(b) Any capitalized terms not specifically defined in this Master Trust Adoption Agreement shall have the meanings ascribed to them in the Master Trust or the other Plan Documents. In the event there is a conflict among the terms of two or more Plan Documents, or in the definition ascribed to any term in two or more Plan Documents, interpretation shall be determined by reference first to the Master Trust, then to this Master Trust Adoption Agreement, then to applicable HRA Plan Coverage Document, then to the Plan Adoption Agreement executed by the Plan Sponsor, then to the applicable Enrollment File, and then to the Participating Trust Document.

(c) Where necessary or appropriate to the meaning thereof, the singular shall be deemed to include the plural, the plural to include the singular, the masculine to include the feminine, the feminine to include the masculine. Any written document referenced herein, including any Plan Document, shall mean such document as amended and restated from time to time.

2. Representations, Warranties, Covenants and Other Undertakings of the Plan Sponsor and Participating Trust Signatory. As of the date hereof and continuously while the Participating Trust participates in the Master Trust, the Participating Trust Signatory and Plan Sponsor hereby agree, represent, warrant and covenant as follows:

(a) The Participating Trust Signatory and Plan Sponsor have full power and authority under the Participating Trust and the provisions of the other Plan Documents relating to the Participating Trust to execute and deliver this Master Trust Adoption Agreement and to accept the terms of the Master Trust, to authorize the Master Trustee, Administrator, and HRA Service Manager as provided in the Master Trust, and to perform the obligations and agreements undertaken by them and the Participating Trust under the Master Trust and this Master Trust Adoption Agreement, and this Master Trust Adoption Agreement constitutes the valid and binding undertaking of the Participating Trust and the Participating Trust Signatory and Plan Sponsor in accordance with its terms;

(b) Copies of the Participating Trust's formation and governing documents, as amended to date (collectively, the "Participating Trust Document"), have been provided to the Master Trustee and the HRA Service Manager, and the Participating Trust Signatory or the Plan Sponsor will provide the Master Trustee and HRA Service Manager with copies of all future amendments to the Participating Trust Document that may affect any party's rights, powers or responsibilities hereunder promptly after their adoption.

(c) The Participating Trust is used to fund the HRA Plan maintained by the Plan Sponsor;

(d) The trustee for the Participating Trust is:

☒ Washington Trust Bank; or

☐ Other – a board, committee, or other person or entity other than Washington Trust Bank, as described below:

_____
_____
_____
_____
_____
_____

(e) The Participating Trust is, and will continue to be as long as it is a Participating Trust [check the one that is applicable]:

☒ i. A trust exempt, under Section 501(c)(9) of the Code, from United States federal income taxation, or

☒ Single-employer; or

☐ Multiple-employer

☐ ii. A trust exempt under Section 115 of the Code, from United States federal income taxation, or

☐ Single-Employer; or

☐ Multiple-employer

☐ A trust ("Taft-Hartley Trust") exempt, under Section 501(c)(9) of the Code, from United States federal income taxation and qualified as a trust under Section 302(c)(5) of the National Labor Relations Act

☐ Single-employer; or

☐ Multi-employer

☐ A grantor (or rabbi) trust exempt from United States federal income taxation based upon the tax exemption of its grantor, the Plan Sponsor, under Section 501(c) or one or more other Sections of the Code as specified below:

_____

_____

_____

_____

(f) Applicability of ERISA.

☒ Check here if the Participating Trust is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

☐ Check here if the Participating Trust is a trust subject to ERISA. To the extent that the Master Trustee holds plan assets under its custody and control on behalf of a Participating Trust subject to ERISA, the Master Trustee acknowledges and agrees that it is a fiduciary with respect to those plan assets. Notwithstanding the foregoing, the Master Trustee's responsibilities as an ERISA fiduciary are expressly limited to serving as a non-discretionary custodian holding title to certain non-interest bearing bank accounts, custodial accounts, funds, and other property on behalf of the Participating Trust for the purpose of administering and facilitating contributions, payment of benefits, and payment of expenses on behalf of the Participating Trust, at the direction of the Administrator (or the HRA Service Manager acting as directed by the Administrator or as specifically provided in the Plan Documents). All other fiduciary duties and responsibilities required under ERISA, including regulatory reporting, disclosures, and filings required by ERISA, have been retained by the Administrator or otherwise delegated by the Administrator to parties other than the Master Trustee.

(g) The Plan Sponsor and Participating Trust Signatory will not change the tax-exempt status of the Participating Trust without prior notification to the HRA Service Manager and Master Trustee in accordance with Section 3 hereof and hereby agree that the Participating Trust shall cease to be a Participating Trust immediately upon the loss or removal of tax-exempt status by the Participating Trust.

3. Duty to Notify. The Participating Trust Signatory and the Plan Sponsor agree that each shall notify the Master Trustee and the HRA Service Manager before or immediately upon any change in federal or state law or amendment to the Participating Trust Document or the occurrence of any event which: (i) causes a change in any of the representations and warranties made by it under this Master Trust Adoption Agreement; (ii) makes participation by the Participating Trust in the Master Trust unlawful or otherwise contrary to the governing documents of the Participating Trust;

(iii) changes the tax exemption of the Participating Trust or could jeopardize the tax exemption or qualification of the Participating Trust or the Master Trust; or (iv) could operate to limit or terminate the authority of the Participating Trust Signatory or the Master Trustee with respect to the Master Trust. The Participating Trust Signatory and Plan Sponsor agree that, in the event any of the above shall occur, (1) the Master Trustee and the HRA Service Manager shall have the right to resign from their roles as Master Trustee and HRA Service Manager and (2) the Participating Trust shall cease to be a Participating Trust.

4. Agreement to Be Bound. The Plan Sponsor and Participating Trust Signatory each agree, for itself and the Participating Trust, and any of their agents, representatives, successors, and assigns, to be bound by the terms of the Master Trust including with those terms that pertain to the authority of the Administrator or HRA Service Manager to direct the Master Trustee as to certain matters specified therein.

5. Designation and Authorization. The Participating Trust Signatory and Plan Sponsor hereby: (i) appoint the Master Trustee as a custodian, transfer agent, and nondiscretionary directed trustee with respect to those assets of the Participating Trust that are transferred or contributed from time to time as part of the Master Trust; and (ii) authorize the Master Trustee, the Administrator, and the HRA Service Manager to do and perform any and all acts with respect to the Master Trust and Participating Trust that the Master Trustee or the HRA Service Manager are authorized, required or permitted to do and perform under the Master Trust and the other Plan Documents.

6. Indemnification. The Participating Trust and the Plan Sponsor will, to the extent permitted by applicable law, indemnify and hold harmless the Master Trustee and the HRA Service Manager and each of their affiliates, agents, subcontractors, officers, employees, successors, and assigns against all actions and proceedings, claims, demands, costs and expenses which may be brought, threatened or incurred by any of them, arising out of an action or inaction by the Plan Sponsor or Participating Trust Signatory that is contrary to the terms of the Participating Trust, the Plan Documents, or applicable law or the failure of the representations and warranties given hereunder by the Plan Sponsor or by the Participating Trust Signatory on its own behalf or on behalf of the Participating Trust to be true, complete and accurate in all material respects. This indemnity will survive the termination of this Master Trust Adoption Agreement and the Master Trust.

7. Term and Amendment. The term of this Master Trust Adoption Agreement shall run from the Effective Date until the date the Participating Trust ceases to be a Participating Trust in the Master Trust as provided therein. This Master Trust Adoption Agreement may only be amended in writing signed by the parties hereto. If any provision that is part of this Master Trust Adoption Agreement shall be found to be void or unenforceable, it shall not affect the remaining provisions which shall remain in full force and effect.

8. Authorizations, etc. The Master Trustee, Plan Sponsor, and the Participating Trust Signatory agree to furnish (or cause its authorized designees to furnish) each other with such authorizations, information and documentation as the other may reasonably request in writing from time to time to enable each of said parties to carry out its obligations under this Master Trust Adoption Agreement and the Master Trust.

9. Counterparts. This Master Trust Adoption Agreement may be executed in one or more counterparts, each of which shall constitute an original, and all of which together will constitute one and the same agreement. Facsimile delivery transmission or electronic delivery in portable document format (".pdf") or tagged image file format (".tif") by any party hereto of its executed counterpart shall constitute the valid and binding execution hereof by such party.

10. Notices. Any notices, reports or other communications permitted or required to be given hereunder or under the Master Trust by or to the Master Trustee, the HRA Service Manager, the Participating Trust Signatory, the Participating Trust, the Plan Sponsor, or the Administrator shall be deemed given to the affected party if delivered in writing to the addresses as set forth in the attached Exhibit A as it may be amended from time to time.

11. Governing Law. This Adoption Agreement and the undertakings herein for the benefit of the parties shall be governed by the laws of the State of Washington, without regard to any conflict of laws.

The remainder of this page is intentionally left blank.

IN WITNESS WHEREOF, the Participating Trust Signatory, Master Trustee, and HRA Service Manager have executed this Master Trust Adoption Agreement as of the date and year set forth below:

Legal Name and Effective Date of Participating Trust:

The Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan

Description of Participating Trust:
(Below please (1) describe the trust document creating the Participating Trust (e.g., Section 115 Trust of City of XYZ or VEBA Trust for the Association of XYZ Worker's Union)

County of Riverside VEBA HSP Plan

Taxpayer Identification Number for Participating Trust:

02-6162571

Each party certifies that the individual signing below has the authority to execute this Agreement on behalf of such party and may legally bind such party to the terms and conditions of the Agreement, including any attachments hereto.

County of Riverside
Participating Trust Signatory
(The signatory of the Participating Trust or such other person designated to have authority under the Participating Trust to adopt the Master Trust. This is typically the Plan Sponsor or trustee under the Participating Trust)

ATTEST:

Clerk of the Board
Kecia R. Harper
By: _____
Deputy

Date: FEB 11 2020

COUNTY OF RIVERSIDE:

By: _____
V. Manuel Perez
Chairman, Board of Supervisors

Date: FEB 11 2020

Approved as to Form:
Gregory P. Priamos
County Counsel

By: _____
Chief Deputy County Counsel
SYNTHIA M. GUNZEL

Accepted by: WASHINGTON TRUST BANK, as Master Trustee

By: _____

Name: Steve Sherman

Title: Vice President

Date: 1-24-2020

By: _____

Name: Rob Blume

Title: Senior Vice President

Date: 01|24|2020

Accepted by: GALLAGHER BENEFIT SERVICES, INC., as HRA Service Manager

By: _____

Name: Charlie Isaacs

Title: Area President

Effective Date:

Exhibit A

Contact Information for Notices

1. The address for delivery of all communications to the HRA Service Manager shall be:

   ATTN: HRA Service Manager
   Gallagher Benefit Services, Inc.
   906 West 2nd Avenue, Suite 400
   Spokane, WA 99201-4502
   (509) 838-5571

2. The address for delivery of all communications to the Master Trustee shall be:

   ATTN: Steve Sherman, Vice President
   Washington Trust Bank
   Wealth Management & Advisory Services
   PO Box 2127
   Spokane, WA 99210-2127
   (509) 353-4106

3. The address for delivery of all communications to the Plan Sponsor and the Administrator is set forth in the Plan Adoption Agreement.

Exhibit B

Master Trust

(Agreement and Declaration)

AMENDMENT AND RESTATMENT OF
AGREEMENT AND DECLARATION OF TRUST

ESTABLISHING THE

HEALTHINVEST HRA MASTER TRUST

EFFECTIVE AS OF

APRIL 1, 2017

FOR

HEALTHINVEST HRA PLANS
FUNDED IN ONE OR MORE TRUSTS
PARTICIPATING IN THE MASTER TRUST

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This AMENDMENT AND RESTATEMENT OF THE AGREEMENT AND DECLARATION OF TRUST (this "Agreement" or "Declaration of Trust") is made as of November 1, 2017, by WASHINGTON TRUST BANK, a trust bank chartered under the laws of the State of Washington, acting in its capacity as a custodian, transfer agent, and nondiscretionary, directed trustee and custodian (the "Master Trustee").

WHEREAS, Gallagher Benefit Services, Inc., ("Gallagher") provides nondiscretionary and ministerial administration support services as the HRA Service Manager, acting on behalf of employers or plan sponsors each of whom have adopted one or more separate and independent health reimbursement arrangement (HRA) plans (each an "HRA Plan" or "Plan" and referred to collectively as the HealthInvest HRA) utilizing Gallagher's proprietary Plan Documents and the services of Gallagher as the HRA Service Manager.

WHEREAS, at Gallagher's request and pursuant to the original Agreement and Declaration of Trust (the "Original Declaration"), Washington Trust Bank created the HealthInvest HRA Master Trust, which is effective as of September 1, 2017 and consists of one or more separate and independently governed sub-trusts or participating trusts through which the HRA Plans are funded for purposes of holding title to HRA Plan assets, including investment assets in one or more custodial accounts and other non-income producing bank accounts and to assist the HRA Service Manager in making certain regulatory filings and reports on behalf of the HRA Plans, based upon direction and authorization of the adopting sub-trusts and adopting plan sponsors.

WHEREAS, the Master Trustee previously undertook through the Original Declaration to act as Master Trustee on behalf of the HRA Plans and Participating Trusts (1) to make, file, or report information on behalf of the HRA Plans, as provided in the HealthInvest HRA Plan Documents and as otherwise directed by the HRA Service Manager or the Administrators of the HRA Plans and (2) to hold in safekeeping as custodian, transfer agent, and nondiscretionary, directed trustee any funds and other property from time to time contributed or transferred to it pursuant to the provisions hereof, as the same may be amended from time to time, together with all the increments, proceeds, investments, and reinvestments thereof, and the income therefrom, in trust, for the uses and purposes and upon the terms and conditions hereinafter set forth.

WHEREAS, the Master Trustee and HRA Service Manager desire to amend this Master Trust to, among other things, clarify the duties of the Trustee and specify the rights of certain parties with respect to the amendment of this Agreement.

NOW, THEREFORE, the following sets forth the terms of this Amended and Restated Agreement and Declaration of Trust.

ARTICLE I

DEFINITIONS AND CONSTRUCTION

1.1 Definitions. As used in this agreement, the following terms shall have the meaning hereinafter set out:

"Administrator" shall mean, with respect to any HRA Plan the assets of which are funded through a Participating Trust, the Plan Sponsor for such HRA plan, or its designee,

who under the Plan Documents is acting in its capacity as the administrator for the HRA Plan either directly or through one or more service providers to whom the Administrator has delegated some or all of its ministerial and nondiscretionary duties. The term "Administrator" used herein may refer to an individual Administrator or refer to all Administrators collectively, as the context indicates.

"Code" shall mean the Internal Revenue Code of 1986, as the same has been or may hereafter be amended.

"Effective Date" of this Agreement and Declaration of Trust is September 1, 2017, and the effective date of this Amended and Restated Declaration of Master Trust is November 1, 2018.

"HRA Plan Document(s)" shall mean one or more of the plan documents that define the terms and conditions of participation and benefits under an HRA Plan, as the same may be amended or amended and restated from time to time.

"Master Trust Adoption Agreement" shall mean the required form of Master Trust Adoption Agreement executed by a Plan Sponsor and Participating Trust Signatory and accepted in writing by the Master Trustee and the HRA Service Manager.

"Master Trust" shall mean the trust created by this Agreement and Declaration of Master Trust, as amended from time to time.

"Master Trustee" is defined in the recitals to this Master Trust.

"Participating Trust" shall mean any trust created for the funding and safekeeping of HRA Plan assets with respect to which the Plan Sponsor for such HRA Plan and the Participating Trust Signatory have executed the Master Trust Adoption Agreement electing to participate in the Master Trust.

"Participating Trust Document" with respect to any Participating Trust, shall have the meaning ascribed to such term in the Master Trust Adoption Agreement.

"Participating Trust Signatory" shall mean, with respect to a Participating Trust, the trustee for the Participating Trust, or such other person or entity authorized under the Participating Trust to adopt and participate in this Master Trust.

"Plan" or "HRA Plan" is defined in the recitals to this Master Trust Agreement.

"Plan Documents" shall mean, with respect to any Participating Trust and HRA Plan, collectively, this Master Trust, the Master Trust Adoption Agreement, the Participating Trust Document, the Plan Adoption Agreement, one or more HRA Plan Documents, and as applied to a particular Participant, the Enrollment File for the Participant, as they same may be amended or amended and restated from time to time.

"Qualified Investment Manager" shall mean any current or future bank, registered investment adviser, or insurance company selected by a Plan Sponsor or Administrator to

manage a portion of the plan assets for any plan, including any investment manager that satisfies the requirements to constitute an "investment advisor" as defined in Section 3(38) of the Employee Retirement Income Security Act of 1974.

"Securities" shall mean and include registered, unregistered and exempt securities issued in accordance with applicable laws, including common and preferred stocks, mutual funds, fixed or variable annuity contracts, contractual obligations of every kind, whether secured or unsecured, equitable interests in real or personal property, and intangible property of every description and howsoever evidenced.

"Tax" or "Taxes" shall mean any tax, taxes, fee or other cost or obligation imposed by any governmental or other similar entity and shall be deemed to include any interest or penalties assessed in respect to such amounts.

1.2 Construction. Where necessary or appropriate to the meaning thereof, the singular shall be deemed to include the plural, the plural to include the singular, the masculine to include the feminine, the feminine to include the masculine. Any written document referenced herein, including any Plan Document, shall mean such document as amended and restated from time to time.

1.3 Terms Incorporated by Reference; Conflicting Provisions. With respect to any Participating Trust and related HRA Plan, capitalized terms used herein and not defined herein shall have the meanings ascribed to such terms in the other applicable Plan Documents. With respect to the interpretation of any particular Plan, in the event there is a conflict among the terms of two or more Plan Documents, or in the definition ascribed to any term in two or more Plan Documents, interpretation shall be determined by reference first to the Master Trust, then to the Master Trust Adoption Agreement, then the applicable HRA Plan Document, then to the applicable Plan Adoption Agreement, then to the applicable Enrollment File, and then to the Participating Trust Document.

ARTICLE II

PURPOSE

2.1 Purpose. The Master Trust has been established to act as a reporting entity on behalf of the HRA Plans for purposes of making certain regulatory filings and reports and to hold title to certain non-interest bearing bank accounts, custodial accounts, funds, and other property on behalf of each of the HRA Plans and Participating Trusts for the purpose of administering and facilitating contributions, payment of benefits, and payment of expenses on behalf of the HRA Plans.

2.2 Grantor Trust. The Trust is intended to be a grantor trust, of which each Participating Trust is the grantor, within the meaning of subpart E, part I, subchapter J, chapter 1, subtitle A of the Code, as amended, and shall be construed accordingly.

2.3 Use of Trust Assets. The Master Trust assets shall be used exclusively to hold title to assets of the Participating Trusts and to facilitate allocation of contributions and payment of

benefits and expenses under the HRA Plans and to defray reasonable expenses of administering the Master Trust.

ARTICLE III

PARTICIPATING TRUSTS

3.1 Eligibility for Participation. A trust through which an HRA Plan is funded may become a Participating Trust if the applicable Plan Sponsor and Participating Trust Signatory of such trust executes a Master Trust Adoption Agreement, and both the Master Trustee and the HRA Service Manager provide written acceptance of such trust as a Participating Trust. Participation in the Master Trust shall commence on the "Effective Date" specified in the applicable Master Trust Adoption Agreement.

3.2 Termination of Participation. A Participating Trust shall cease to be a Participating Trust on the date on which:

(a) The Participating Trust Signatory or the Plan Sponsor for the underlying HRA Plan, notifies the HRA Service Manager or the Master Trustee in writing of its desire to terminate participation of the Participating Trust in the Master Trust; or

(b) The Participating Trust ceases to be a Participating Trust under the terms of this Declaration of Master Trust or the Master Trust Adoption Agreement; or

(c) The Master Trust is terminated.

3.3 Non-assignability. A Participating Trust may not assign or transfer its interest in the Master Trust or in any part thereof without prior written consent of the HRA Service Manager and Master Trustee.

ARTICLE IV

FUNDING

4.1 Contributions. Participating Trusts and their underlying HRA Plans shall contribute or transfer to the Master Trust such amount or amounts determined through the operation and administration of the HRA Plans in accordance with the applicable Plan Documents. All contributions and transfers shall be held, administered, and distributed, in trust, under the terms of this agreement. The Master Trustee shall not be under any duty to inquire into the timeliness or correctness of the amounts contributed, transferred and delivered to the Master Trustee hereunder; nor shall the Master Trustee or any other person be under any duty to enforce the payment of the contributions to be made hereunder and each Participating Trust agrees to indemnify and hold harmless the Master Trustee in connection therewith. The Master Trustee shall not be responsible for the calculation or collection of any contributions under or referred to by HRA Plans and shall have no duties, except as specified under this agreement, for the administration of the Master Trust. Nothing in this agreement shall entitle the Master Trustee or any other person or entity to inquire into or demand the right to inspect the books of the Employers, Plan Sponsors, Administrators, or Trustees of the HRA Plans or Participating Trusts.

Notwithstanding any provision of this agreement to the contrary, no Employer, Plan Sponsor, Administrator, or Participating Trust shall be required to continue to fund benefits under any HRA Plan through the applicable Participating Trust or this Master Trust.

4.2 Revocability of Contributions. All contributions and transfers made to the Master Trust shall be revocable and shall be returned to the Participating Trust upon request of the applicable Plan Sponsor or Participating Trust Signatory or upon termination of the Participating Trust's participation in this Master Trust.

4.3 Assets Held with Respect to a Particular Participating Trust. The Master Trustee shall receive the contributions from each Participating Trust or transfers in cash or other property acceptable to it. All consideration received by the Master Trust, together with all assets in which such consideration is invested or reinvested, all income, earnings profits, and proceeds thereof from whatever source derived (including, without limitation, any proceeds derived from the sale, exchange or liquidation of such assets and any funds or payments derived from any reinvestment of such proceeds in whatever form the same may be), shall, in accordance with the terms of the applicable Plan Documents and this Master Trust, be accounted for and held separately with respect to each Participating Trust and each Plan and each Employer Account or Participant Account (each referred to as an "Account") thereunder for all purposes and shall be so recorded upon the books of account of the Master Trust. The consideration, assets, income, earnings, profits and proceeds thereof, from whatever source derived, (including, without limitation, any proceeds derived from the sale, exchange or liquidation of assets, and any funds or payments derived from any reinvestment of proceeds, in whatever form the same may be) are herein referred to as "assets held with respect to" each Participating Trust and each Plan and Account thereunder. In the event that there are any assets, income, earnings, profits and proceeds thereof, funds or payments that are not readily identifiable as assets held with respect to any Participating Trust and or the Plans or Accounts thereunder (collectively "General Assets"), the Master Trustee shall allocate General Assets to, between or among any one or more of the Participating Trusts and the Plans and Accounts thereunder based upon the direction of the HRA Service Manager, acting on behalf of the Participating Trusts in accordance with the Plan Documents or otherwise at the direction of the Participating Trust Signatories, and any General Assets so allocated to a Participating Trust, Plan, or Account shall be held with respect to that Participating Trust, Plan, or Account. Each allocation by the Master Trustee at the direction of HRA Service Manager shall be conclusive and binding upon the Participating Trusts, their underlying HRA Plans, and all associated Employers and Participants for all purposes. The HRA Service Manager, or its designee, shall maintain separate and distinct sub-accounting records for each Participating Trust and each Plan and Account thereunder on behalf of the Master Trustee, and the HRA Service Manager, or its designee, shall hold and account for the assets with respect to each Participating Trust and each Plan and Account thereunder separately from the assets held with respect to all other Participating Trusts and Plans and Accounts thereunder.

4.4 Liabilities Associated with Respect to a Particular Participating Trust. With respect to each Participating Trust and each Plan and Account thereunder, the liabilities, expenses, costs, charges, and reserves associated with such Participating Trust, Plan, or Account shall be charged against the assets of the Master Trust held with respect to such Participating Trust, Plan, or Account. Any liabilities, expenses, costs, charges and reserves of the Master Trust that are not readily identifiable as being associated with any particular Participating Trust or any Plan or

Account thereunder ("General Liabilities") shall be allocated and charged by the Master Trustee to and among any one or more of the Participating Trusts or to and among the Plans and Accounts thereunder based upon the direction of the HRA Service Manager, acting on behalf of the Participating Trusts in accordance with the Plan Documents or otherwise at the direction of the Participating Trust Signatories, and any General Liabilities so allocated to a particular Participating Trust or Plan or Account thereunder shall be charged against the assets of that Participating Trust, Plan, or Account. Each allocation of liabilities, expenses, costs, charges and reserves by the Master Trustee at the direction of the HRA Service Manager shall be conclusive and binding upon the Participating Trusts their underlying HRA Plans, and the applicable Employers and Participants for all purposes. All liabilities, expenses, costs, charges and reserves so charged to a Participating Trust, Plan or Account are herein referred to as "liabilities associated with" that Participating Trust, Plan, or Account. Without limiting the foregoing, but subject to the right of the Master Trustee to allocate liabilities, expenses, costs, charges or reserves as herein provided, the liabilities associated with a particular Participating Trust or underlying Plan or Account shall be enforceable against the assets held with respect to that Participating Trust or underlying Plan or Account only and not against the assets of the Master Trust generally or against the assets held with respect to any other Participating Trust or the Plans or Accounts thereunder. The HRA Service Manager, or its designee, shall maintain separate and distinct sub-accounting records for each Participating Trust, Plan, and Account thereunder on behalf of the Master Trustee, and the HRA Service Manager, or its designee, shall account for the liabilities with respect to each Participating Trust and its underlying Plans and Accounts separately from the liabilities held with respect to all other Participating Trusts, Plans, and Accounts thereunder.

ARTICLE V

POWERS AND DUTIES OF THE MASTER TRUSTEE AND HRA SERVICE MANAGER

5.1 Trust Property and Investments.

(a) In addition to all powers and duties otherwise expressly set forth in this agreement and subject to the provisions of Section 5.5, the Master Trustee shall have the following powers with respect to each Participating Trust, exercised only at the direction of the Administrator for each Plan or its Qualified Investment Managers or other designees:

(i) to invest and reinvest all or any part of the Master Trust, including both principal and income, in Securities and other property;

(ii) to insure the payment of benefits under a contract or contracts with an insurance company or companies, and hold and retain such contract or contracts as part of the Master Trust;

(iii) to sell, lease, exchange, pledge or grant a security interest in, or otherwise dispose of all or any part of the Master Trust;

(iv) to exercise all voting rights, tender or exchange rights, any conversion privileges, subscription rights, and other rights and powers available in connection with any Securities or other property at any time held hereunder;

(v) to enter into or oppose any plan of consolidation, merger, reorganization, capital readjustment, or liquidation of any corporation or other issuer of Securities held hereunder including the exercise of any option, the making of any agreements or subscriptions and the payment of expenses, assessments or subscriptions, plan for the sale, lease, or mortgage of any of its property or the adjustment or liquidation of any of its indebtedness and, in connection with any such plan, to enter into any other such agreement, and to pay assessments or subscriptions from the other assets held hereunder;

(vi) to retain in cash or otherwise in a form unproductive of income such portion of the Master Trust as is necessitated by the cash requirements of the HRA Plans; provided, however, that, to the extent feasible, such amounts shall be held in forms of investment which are productive of income but are sufficiently liquid to meet such cash requirements;

(vii) to invest in collective investment funds maintained by Washington Trust Bank of Spokane or by other banks for the investments of assets of employee welfare benefit plans, whereupon the instruments establishing such funds, as amended, shall be deemed part of this Master Trust and incorporated herein by reference;

(viii) to deposit securities held hereunder in any depository;

(ix) to deposit all or any part of the Master Trust, including both principal and interest, in any bank organized under the national banking laws of the United States or under the laws of any State, including Washington Trust Bank of Spokane.

(b) Separate investments, assets, custodial accounts, bank accounts, and title in other properties shall not be required to be maintained with respect to separate Participating Trusts and any Plans or Accounts thereunder; rather, the same may be aggregated on an omnibus basis, together with investments assets, custodial accounts, bank accounts, and property of all Participating Trusts and any Plans or Accounts. On behalf of the Master Trustee, the HRA Service Manager shall maintain for the Master Trustee separate and distinct sub-accounting records for the Participating Trusts and any Plans or Accounts thereunder such that each shall have a divided interest in specific assets and property held by the Master Trust. No Participating Trust shall have any interest in the specific assets or property held by the Master Trust on behalf of any other Participating Trust.

(c) The Plan Sponsor or Administrator for each Plan shall select one or more Qualified Investment Managers to determine which investment options are to be available for the holding and investment of Trust assets and to evaluate and monitor the performance of those options. The Master Trustee shall not be obligated or required to evaluate or

monitor the qualifications or performance of any Qualified Investment Manager or to determine which investment options are to be available for the holding and investment of assets in the Master Trust or to evaluate and monitor the performance of those options. The Qualified Investment Manager shall have the power to direct the Master Trustee with respect to such investments, and the Master Trustee shall be under no duty to question, and shall not incur any liability on account of following, any direction of a Qualified Investment Manager with respect to such investments. The Master Trustee shall be under no duty to review the investment guidelines, objectives and restrictions established, or the specific investment instructions given, by the Administrator to such Qualified Investment Manager or to make suggestions to the Administrator in connection therewith.

(d) The Master Trustee shall transmit to the HRA Service Manager (who shall promptly transmit to the applicable Qualified Investment Manager), all notices of conversion, redemption, tender, exchange, subscription, class action, claim in insolvency proceedings or other rights or powers relating to any of the Securities held hereunder, which notices are received by the Master Trustee from its agents or custodians, from the issuers of the Securities in question and from the party (or its agents) extending such rights. The Master Trustee shall have no obligation to determine the existence of any conversion, redemption, tender, exchange, subscription, class action, claim in insolvency proceedings or other rights or powers relating to any of the Securities held hereunder of which notice was given prior to the purchase of such Securities held hereunder, and shall have no obligation to exercise any such right or power unless the Master Trustee is informed of the existence of the right or power.

(e) The Master Trustee shall not be liable for any untimely exercise or assertion of such rights or powers described in the paragraph immediately above in connection with Securities or other property held hereunder at any time unless (i) it or its agents or custodians are in actual possession of such securities or property and (ii) it receives directions to exercise any such rights or powers from the Qualified Investment Manager, and both (i) and (ii) occur at least three business days prior to the date on which such rights or powers are to be exercised.

(f) If the Master Trustee is directed by a Qualified Investment Manager to purchase Securities issued by any foreign government or agency thereof, or by any corporation or other entity domiciled outside of the United States, it shall be the responsibility of the Qualified Investment Manager, as the case may be, to advise the Master Trustee in writing with respect to any laws or regulations of any foreign countries or any United States territory or possession which shall apply in any manner whatsoever to such Securities, including, without limitation, receipt by the Master Trustee of any dividends, interest or other distributions on such Securities.

(g) The Administrator for each Plan shall direct the Master Trustee in writing as to what percentage of which Participant and Employer Accounts should be invested in which investment option, as elected by the applicable Participant or Employer. If no such direction is received from the Administrator, the Master Trustee shall invest the Trust assets associated with that Account in in a default investment designated by the Qualified Investment Manager.

5.2 Claims Against Trust. Subject to the provisions of Section 5.5, and except as regards benefits under the HRA Plans, the Master Trustee is empowered to compromise and adjust any and all claims, debts, or obligations in favor of or against the Master Trust, whether such claims be in litigation or not, and to reduce the rate of interest on, to extend or otherwise modify, or to foreclose upon default, or otherwise enforce any such claim, debt, or obligation.

5.3 Borrowing. Subject to the provisions in Section 5.5, the Master Trustee is empowered to borrow money in such amounts and upon such terms and conditions as shall be deemed advisable or proper to carry out the purposes of the Master Trust and to pledge any Securities or other property for the repayment of any such loan; provided, however, no such loan shall be made by the Master Trustee individually other than a temporary advancement to the Master Trust on a cash or overdraft basis.

5.4 Registration of Securities; Nominees; Account Signatories.

(a) The Master Trustee is empowered to register Securities in its own name, or in the name of its nominee, agent, or custodian without disclosing the Master Trust, or to hold the same in bearer form, and to take title to other property in its own name or in the name of its nominee, agent, or custodian without disclosing the Master Trust; but the Master Trust shall be responsible for the acts of its nominee, agent, or custodian.

(b) The Master Trustee is empowered to authorize the HRA Service Manager or its designee as signatory to any bank accounts established on behalf of the Participating Trusts and their underlying HRA Plans for purposes of administration and facilitation of the allocation of contributions and payment of benefits and expenses for the HRA Plans. Each Participating Trust, Participating Trust Signatory, Plan Sponsor, and Administrator agrees, to the fullest extent permitted by law, to indemnify and hold the Master Trustee harmless for damages resulting from the acts of the HRA Service Manager or its designee in their capacity as agent or signatory on such accounts.

5.5 Directions From HRA Service Manager. To the extent permitted by applicable law, the powers conferred upon the Master Trustee in this agreement, including Sections 4.3, 4.4 and 5.1, shall at all times be subject to the direction of the Administrator for each Plan, which shall direct the Master Trustee as to all such matters relating to administration of the Master Trust as specified in the Plan Documents. The Administrator for each Plan shall, at any time and from time to time, certify to the Master Trustee in writing the name or names of any person authorized to act for the Administrator, with respect to the exercising of any one or more of such powers of the Administrator. Toward that end, pursuant to the Plan Adoption Agreement, the HRA Service Manager and any of its designees, officers, employees, subcontractors, agents, and representatives, are designated by the Administrator for each Plan as persons authorized to act on behalf of the Administrator with respect to exercising any one or more powers of the Administrator as specifically set forth in this agreement and the other Plan Documents or as otherwise directed by the Administrator. Until the Administrator notifies the Master Trustee that any such person is no longer authorized to act for the Administrator, the Master Trustee may continue to rely on the authorization of such person. The Master Trustee shall be under no duty or obligation to review any instruction it so receives, except that the Master Trustee shall have no obligation by reason of any such direction to make any advance or loan in its banking capacity. The Master Trustee shall

have no liability or responsibility for acting without question on the direction of, or failing to act in the absence of any direction, unless the Master Trustee has knowledge that by such action or failure to act it will be participating in or undertaking to conceal a breach of fiduciary duty. The Participating Trusts agree to indemnify and hold harmless the Master Trustee and the HRA Service Manager for acting in accordance with this Section 5.5.

5.6 Agents, Attorneys, Actuaries, Consultants, Administrators and Accountants. The Master Trustee is empowered to employ such agents, attorneys, actuaries, consultants, administrators, accountants and other service providers as may be deemed necessary or proper in connection with its duties hereunder, and, upon the written authorization or direction of the Administrator for each Plan, to determine and pay out of the assets of the Master Trust the reasonable compensation and expenses of such agents, attorneys, actuaries, consultants, administrators, accountants and other service providers.

5.7 Other Authority. The Master Trustee is authorized to execute and deliver any and all instruments and to perform any and all acts which may be necessary or proper to enable it to discharge its duties under this agreement and to carry out the power and authority conferred upon it.

5.8 Directions to the Master Trustee. The Master Trustee may rely on any written direction, request, approval, or other document purporting to have been signed on behalf of the Administrator for each Plan by the person authorized to act for the Administrator.

5.9 Payment of Taxes; Indemnity. The Master Trustee is empowered to pay out of the assets of the Master Trust, as a general charge thereon, any and all Taxes or governmentally imposed fees and charges of whatsoever nature assessed on or in respect thereto; provided, however, that if an Administrator for any Plan shall notify the Master Trustee in writing that any such Tax or governmentally imposed fee or charge is not lawfully or properly assessed, or is questionable, the Master Trustee, if so requested by the Administrator, shall contest the validity of such Tax in any manner deemed appropriate by the Administrator. Unless the Master Trustee shall first have been indemnified to its satisfaction by the Administrator and the applicable Participating Trust(s), the Master Trustee shall not be required to contest the validity of any Tax, to institute, maintain, or defend against any other action or proceeding, or to incur any other expense in connection with the Master Trust, except to the extent that the same is sufficient therefor.

5.10 Compensation and Expenses. The Master Trustee shall be entitled to such compensation for its service and reimbursement for all reasonable expenses incurred by the Master Trustee in the administration of the Master Trust, in accordance with the terms of the Plan Adoption Agreement between each Plan Sponsor and the HRA Service Manager or as otherwise agreed in writing between the Master Trustee and the Plan Sponsor. Such compensation and expenses shall be paid from the assets of the Participating Trusts or as otherwise agreed in writing by the Plan Sponsor of each Participating Trust.

5.11 Records and Statements; Tax or Regulatory Filings. The Master Trustee shall keep accurate records of all receipts, disbursements, and other transactions affecting the Master Trust, which, together with the assets comprising the Master Trust and all evidences thereof, shall be available during the Master Trustee's usual business hours for inspection or for the purposes of

making copies or reproductions thereof by the HRA Service Manager, upon the reasonable request of the HRA Service Manager on behalf of one or more of the Administrators. The Master Trustee shall render to the HRA Service Manager, monthly and annually, statements of receipts, disbursements, and all transactions during the preceding period affecting the Master Trust and a statement of all assets then held by it hereunder. The Master Trustee shall not be responsible for the completion or filing of annual tax or regulatory returns or filings (such as IRS Form 990 or DOL Form 5500, etc.) applicable to any Participating Trust or Plan, which shall be the responsibility of each Participating Trust or Plan Sponsor or its employees, agents, service providers, or other designees, and the Master Trust shall have no duty or obligation to confirm whether such returns or filings are required or have been made by the Participating Trust or Plan. The Master Trustee shall be responsible for completion and filing only of all tax returns or reports applicable to the Master Trust.

5.12 Court Action Not Required. All the powers and authority herein conferred upon the Master Trustee shall be exercised by it without the necessity of applying to any court for leave or confirmation. No person dealing with the Master Trustee shall be required to ascertain whether the Master Trustee shall have obtained the approval of any court or of any person to any action which it may propose to take hereunder, but every such person may rely solely upon the deed, transfer, or assurance of the Master Trustee.

5.13 Disputes. If a dispute arises as to the payment of any funds or delivery of any assets by the Master Trustee, the Master Trustee may withhold such payment or delivery until the dispute is resolved by a court of competent jurisdiction or finally settled in writing by the concerned parties.

5.14 Role of the HRA Service Manager. The powers and responsibilities of the HRA Service Manager specified herein and in the other Plan Documents for each Participating Trust and its underlying Plans are non-discretionary and are intended for the purpose of effecting the efficient administration of this Master Trust and each Participating Trust and Plan for the benefit of and subject to the direction or approval of the Plan Sponsor, Employer, Administrator, or Employee Representative for such Plan, as specified herein or in the Plan Documents, and such powers and responsibilities are subject to the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the applicable Plan Adoption Agreement.

ARTICLE VI

DISPOSITION OF TRUST ASSETS

6.1 Payments from the Trust. Unless and until the Master Trust is terminated as provided herein, the Master Trustee shall make payments from the Master Trust for the benefit of each Participating Trust and its underlying HRA Plan or to pay reasonable expenses of administering the Master Trust, as directed by the Administrator for each Plan.

6.2 Excess Assets. Any excess assets remaining in the Master Trust upon satisfaction of all liabilities and requirements of the Master Trustee hereunder, shall be applied by the Master Trustee as directed.

ARTICLE VII

SUCCESSION TO THE TRUSTEESHIP

7.1 Resignation of the Master Trustee. Any Master Trustee acting hereunder may resign at any time by giving notice in writing to the HRA Service Manager on behalf of the Administrator for each HRA Plan at least ninety (90) days before such resignation is to become effective, unless the HRA Service Manager on behalf of the Administrators shall accept as adequate a shorter notice.

7.2 Removal of the Master Trustee. Based upon the authority granted to the HRA Service Manager, and subject to the HRA Manager's right to resign and each Plan Sponsor's right to remove the HRA Service Manager under the applicable Plan Adoption Agreement, the HRA Service Manager may remove, with or without cause, any Master Trustee acting hereunder by giving notice in writing to such Master Trustee at least ninety (90) days before such removal is to become effective, unless the Master Trustee shall accept as adequate a shorter notice.

7.3 Appointment of a Successor Trustee. If for any reason a vacancy should occur in the master trusteeship, the HRA Service Manager on behalf of the Administrators shall forthwith appoint a successor Master Trustee, which appointment is subject to the HRA Manager's right to resign and each Plan Sponsor's right to remove the HRA Service Manager set forth in the applicable Plan Adoption Agreement. A successor Master Trustee may be either a corporation authorized to carry on a trust business or a national banking association or such person or persons or committee as deemed appropriate by the HRA Service Manager. Any successor Master Trustee appointed hereunder shall execute, acknowledge, and deliver to the HRA Service Manager and the predecessor Master Trustee an instrument in writing accepting such appointments hereunder. Such successor Master Trustee thereupon shall become vested with the same title to the Master Trust property, and the same powers and duties with respect thereto, as are hereby vested in the predecessor Master Trustee. The HRA Service Manager shall deliver to the Administrators, Plan Sponsors, and Employers notice of any replacement Master Trustee within 90 days after the effective date thereof. The predecessor Master Trustee shall execute all such instruments and perform all such other acts as the successor Master Trustee shall reasonably request to effectuate the provisions hereof. The successor Master Trustee shall have no duty to inquire into the administration of the Master Trust for any period prior to its succession. No Master Trustee shall have any liability, duty, or other obligation with respect to actions or omissions of any successor or predecessor Master Trustee.

ARTICLE VIII

AMENDMENT AND TERMINATION

8.1 Right of Amendment. The Master Trustee may amend the terms of this Master Trust from time to time, subject to acceptance of such amendment by the HRA Service Manager on behalf of the Administrator and Participating Trusts in accordance with the terms of the Plan Documents or as otherwise directed by the Administrator. The Master Trustee shall make no amendment to the terms of this Master Trust that shall permit any part of the assets or property of a Participating Trust to be used for or be diverted to purposes other than the exclusive benefit of

the Participating Trusts unless such amendment is otherwise permitted by applicable law necessary to ensure that income of the Trust is not subject to federal or state income tax and as will not result in the imposition of an excise tax under any Section of the Code. Any amendment to the terms this Master Trust (as amended and restated as of November 1, 2017) shall be delivered in writing by the HRA Service Manager to the Plan Sponsors for each Plan at least thirty (30) days prior to the proposed effective date of such amendment. If on or before the proposed effective date of such amendment the Plan Sponsor for any Plan has not delivered a written notice to the HRA Service Manager objecting to the amendment, the amendment will be deemed to be approved by such Plan Sponsor. A Plan Sponsor's disapproval of any amendments to the terms of this Master Trust are subject to the HRA Manager's right to resign and each Plan Sponsor's right to remove the HRA Service Manager set forth in the applicable Plan Adoption Agreement. Notwithstanding the stated effective date of any amendment, such amendment may by its terms be prospective or retroactive as provided therein.

8.2 Resignation or Removal of HRA Service Manager. In accordance with the Plan Adoption Agreement for any HRA Plan, if the HRA Service Manager resigns or is removed for any reason, the Plan Sponsor shall, pursuant to the terms of the applicable Plan Adoption Agreement for such HRA Plan, transfer all Plan assets to another service provider or another welfare benefit plan prior to the effective date of such resignation or removal, unless a longer time period for transfer is agreed upon in writing between the HRA Service Manager and the Plan Sponsor. In such event, the Plan Sponsor Trust shall cease to be a Participating Trust hereunder, and the Master Trustee shall transfer all Plan assets for such HRA Plan at the direction of the Plan Sponsor or other Participating Trust Signatory for the Plan Sponsor Trust.

8.3 Termination of an HRA Plan. In accordance with the Plan documents for any HRA Plan, the Plan Sponsor may terminate its HRA Plan or cause all Plan assets to be transferred to another welfare benefit fund for the benefit of its Participants. In such event, the Plan Sponsor Trust shall cease to be a Participating Trust hereunder, and the Master Trustee shall transfer all Plan assets for such HRA Plan at the direction of the Plan Sponsor or other Participating Trust Signatory for the Plan Sponsor Trust.

8.4 Termination of all HRA Plans. In the event of a termination of all of the HRA Plans pursuant to the Plan Documents, the assets of the Master Trust shall be held, administered, and distributed by the Master Trustee in accordance with the terms of the Plan Documents and this Master Trust or as otherwise directed by the Plan Sponsor or other Participating Trust Signatory for each Participating Trust.

ARTICLE IX

MISCELLANEOUS

9.1 Validity of Agreement. The validity of this agreement shall be determined and this agreement shall be construed and interpreted in accordance with the laws of the State of Washington. If any provision of this agreement is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining portions of the agreement unless such illegality or invalidity prevents accomplishment of the objectives and purposes of the Master Trust. In the

event of any such holding, the Master Trustee may immediately, and if in accordance with appropriate law retroactively, amend the agreement as is necessary to remedy any such defect.

9.2 General Indemnification. To the extent permitted by applicable law, with respect to each HRA Plan and Participating Trust, the Plan Sponsor for such Plan shall indemnify and hold the Trustee harmless from any loss or expense (including reasonable attorneys' fees) arising (a) out of an authorized action hereunder taken in good faith by the Trustee or any matter as to which this Trust provides that the Trustee is directed, protected, not liable, or not responsible or (b) by reason of any breach of any statutory or other duty owed to the HRA Plan by the Employer, Plan Sponsor, Administrator (if different than the Plan Sponsor), the HRA Service Manager or any Qualified Investment Manager or any delegate of any of them (and for the purposes of this sentence the Trustee shall not be considered to be such a delegate) whether or not the Trustee may also be considered liable for that other person's breach under federal, state, local or other law, unless such other person's breach for which the Trustee is considered liable arose out of the gross negligence or willful misconduct of the Trustee.

9.3 No Guarantees. With respect to each Participating Trust and HRA Plan, neither the HRA Service Manager, the Plan Sponsor, the Administrator, the Employer, nor the Master Trustee guarantees the Master Trust from loss or decline in value, nor the payment of any amount which may become due to any person hereunder. Nothing contained in the Master Trust shall constitute a guarantee by the HRA Service Manager, the Plan Sponsor, the Administrator, the Employer, or the Master Trustee that the assets of the Master Trust will be sufficient to pay any benefit to any person or make any other payment under any Participating Trust or HRA Plan; payments to be paid from the Master Trust are limited to the assets remaining in the applicable Participating Trust, Participant Account or Employer Account at the time payment is made. Prior to the time that distributions are made in conformity with any Plan, the applicable Participating Trust, and the Master Trust, no Employees, Participants, or other persons shall receive any distribution of cash or other thing of current or exchangeable value, either from the HRA Service Manager, the Plan Sponsor, the Administrator, the Employer or the Master Trustee on account of, or as a result of the trust fund created hereunder.

9.4 Duty to Furnish Information. With respect to any Participating Trust or HRA Plan, the Administrator and the Master Trustee each shall furnish to the other any documents, reports, returns, statements, or other information that the other reasonably deems necessary to perform its duties imposed under the Plan or this agreement or otherwise imposed by law. The Master Trustee shall furnish to each Administrator any documents, reports, returns, statements, or other information that the Administrator reasonably deems necessary to perform its duties and exercise its rights hereunder, under the other Plan Documents, and otherwise under the Plan.

9.5 Reliance of Communications. With respect to any Participating Trust or HRA Plan, the Master Trustee may rely upon a written certification of the HRA Service Manager with respect to any instruction, direction or approval of the HRA Service Manager and may rely on the written certification of the Administrator as to any matter relating to this Master Trust. The Master Trustee shall be fully protected and indemnified by the applicable Participating Trust and Plan Sponsor in acting upon any instrument, certificate or paper of the HRA Service Manager or Administrator believed by the Master Trustee to be genuine and to be executed or presented by any authorized person of the HRA Service Manager or Administrator, and the Master Trustee shall be under no

obligation or duty to make any investigation or inquiry as to any statement contained in any such writing but may accept the same as fully authorized by the HRA Service Manager or Administrator. Moreover, the Master Trustee shall be fully protected and indemnified in relying upon a written certification of any Qualified Investment Manager appointed by Plan Sponsor with respect to the person or persons authorized to give any instructions or directions on behalf of such Qualified Investment Manager and may continue to rely on the written certification until a subsequent written certification is filed with the Master Trustee.

9.6 Taxes. The Master Trustee shall withhold any Tax which by any present or future law is required to be withheld from any payment hereunder.

9.7 Rebates and Adjustments. In the event a benefit is provided or a disbursement is made from the Master Trust and it is determined by the Master Trustee or the Administrator for any Plan that such benefit should not have been provided or disbursement made, the Administrator or the HRA Service Manager may arrange for a contribution from one or more Participating Trusts to which the disbursement was made, to reimburse the Master Trust or engage in efforts to seek the return of the benefit or disbursement. The Master Trustee shall be under no duty or obligation to inquire into the correctness of any determination made by the Administrator resulting in a direction to the Master Trustee under this provision.

9.8 Inalienability of Benefits. Except as may otherwise be provided herein, the right of any Participant or other person or entity to any benefit or payment from the Master Trust shall not be subject to voluntary or involuntary transfer, alienation, pledge, assignment or other disposition and shall not be subject to attachment, execution, garnishment, sequestration or other legal or equitable process. Any attempt to transfer, alienate, pledge, assign or otherwise dispose of such right or any attempt to subject such right to attachment, execution, garnishment, sequestration or other legal or equitable process shall be null and void, unless such action is approved by the Master Trustee and the Administrator for the applicable Plan and undertaken in accordance with the terms and provisions of this Master Trust, the Participating Trust, and the Plan Documents.

9.9 No Implied Rights. Neither the establishment of the Master Trust nor any modification thereof, nor the creation of any fund, trust or account thereunder, shall be construed as giving any Participant or other person or entity any legal or equitable right unless such right shall be specifically provided for herein or in the applicable Plan Documents or conferred by affirmative action of the Plan Sponsor or Employer in accordance with applicable law and the express written terms and provisions of the Master Trust and the other Plan Documents.

9.10 Status of Employment Relations. The adoption and maintenance of the Master Trust shall not be deemed to constitute a contract between any Employer and its Employees or any representative thereof or to be consideration for, or an inducement or condition of, the employment of any person. Nothing contained herein shall be deemed to:

(a) give to any Employee the right to be retained in the employ of his or her Employer;

(b) affect the right of the Employer to discipline or discharge any Employee at any time; or

(c) affect any Employee's right to terminate his employment at any time.

9.11 Parties Bound. This agreement shall be binding upon the Master Trustee, the HRA Service Manager, and all Participating Trusts, Participating Trust Signatories, Plan Sponsors, Administrators, Employers, Employees, Participants, and, as the case may be, the Dependents, heirs, executors, administrators, successors, and assigns of each of them.

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

IN WITNESS WHEREOF, Washington Trust Bank has caused this Amendment and Restatement of Agreement and Declaration of Trust to be executed by its duly authorized officers and respective seals to be hereunder affixed as of November 28th, 2018.

ATTEST:

Name: Mick Buller, Vice President

Name: Chad LeGate, Vice President

WASHINGTON TRUST BANK, a trust bank chartered under the laws of the State of Washington

By:

Name: Robert Blume

Title: Senior Vice President

Date: November 28, 2018

By:

Name: Steve Sherman

Title: Vice President

Date: November 28, 2018

Exhibit C

Plan Sponsor Trust Agreement

Include executed copy of primary trust agreement.

☐ Option 1: Complete and sign the HealthInvest HRA form of Plan Sponsor Trust Agreement provided by the HealthInvest HRA Service manager.

☒ Option 2: Provide your previously executed trust that has been approved by the HealthInvest HRA Service Manager.

This is the primary trust agreement created for the safekeeping of your HRA Plan assets and will be attached as Exhibit A to the Master Trust Adoption Agreement. This trust will become a Participating Trust under the HealthInvest HRA Master Trust pursuant to the Master Trust Adoption Agreement.

Part 2

Plan Adoption Documents

Items listed in **bolded blue text** and marked with an asterisk (*) are documents that must be completed and/or signed by an authorized officer of the Plan Sponsor. Read **Plan Adoption Instructions** on page 52 for more details.

Plan Adoption Instructions 52

Plan Sponsor Contact Information Form* 53

Plan Adoption Agreement* 54

Plan Design Elections and Administration

Addendum A: Plan Design Elections* 65

Addendum B: Participant Account Elections* 69

Addendum C: Administrative Fees Schedule, Plan Representatives, and Plan Administration Support Services 74

Investment Management

Addendum D: Investment Management Services 80

HIPAA

Addendum E: HIPAA Business Associate Agreement* 85

*Must be completed and/or signed by an authorized officer of the Plan Sponsor.

Capitalized terms used throughout this set of **Plan Adoption** documents and not otherwise defined herein shall have the meaning given to such terms in the other **Plan Documents**, as amended from time to time. The **Plan Documents** governing the terms and conditions of plan coverage are provided separately.

In addition to this set of **Plan Adoption** documents, you must also execute the **Trust Adoption** documents.

Plan Adoption Instructions

Please carefully follow the instructions below. All actions are required unless otherwise noted.

For your convenience, all documents are designed to be executed electronically, including the signature pages. Just follow the prompts.

Your completed Plan Adoption documents will be reviewed and countersigned by Gallagher Benefit Services, Inc. (GBS) as the HRA Service Manager. We will maintain an electronic countersigned copy and email a duplicate copy to you or your designated contact. You, as Plan Sponsor, should keep all executed documents on file.

☐	Page 53:	**Provide your contact information:** Complete the **Plan Sponsor Contact Information** form.
☐	Page 54:	**Establish your Plan:** Sign the **Plan Adoption Agreement.**
☐	Page 65:	**Design your Plan:** Make your **Plan Design Elections** (Addendum A).
☐	Page 69:	**Define your Participant Account types:** Make your **Participant Account Elections** (Addendum B).
☐	Page 85:	**Agree to terms regarding the use and/or disclosure of Protected Health Information:** Complete and sign the **HIPAA Business Associate Agreement** (Addendum E).

HealthInvest HRA

PLAN SPONSOR CONTACT INFORMATION

1. EMPLOYER (PLAN SPONSOR) INFORMATION

Plan Sponsor Name: County of Riverside

Plan Sponsor Address: 4080 Lemon Street (Street Address) Riverside (City) CA (State) 92502 (Zip)

Plan Sponsor Phone: (951)955-4981 Plan Sponsor Fax: (951)955-8538

Plan Sponsor Tax Identification Number: 02-6162571

2. CONTACT INFORMATION

a) Contact for Enrollment/Payroll/Contribution Matters(1)

Contact Name: Amy Onopas Title: _ County Benefits Plan Administrator

Phone: (951) 955-4981 E-mail: retirement@rivco.org

(1) This person will receive a copy of the Plan Sponsor Welcome Kit and will be contacted by the HRA Service Manager or other Plan representative to confirm enrollment and contribution procedures.

b) Contact for General Plan Communications:(2)

Contact Name: Same as above Title:

Phone: E-mail:

(2) Here please identify the principal business or administrative contact who will need to receive official Plan communications (such as Plan amendments) and other time sensitive administrative and operational communications and information. This person will receive the counter-signed Adoption Agreement and Plan Sponsor Welcome kit.

c) Contact for Plan Sponsor Account Matters:(3)

Contact Name: Stacey Beale Title: HR Division Manager

Phone: E-mail:

(3) If applicable, please identify the administrative or operational contact who will need to receive information regarding any Plan Sponsor Account established under the Plan, such as account statements, confirmations, etc.

c) Identify Plan Sponsor's Privacy and Security Officials:(4)

Contact Name: Title: _ HIPAA Privacy Manager

Phone: (951)486-6471 Address: 26520 Cactus Avenue, Moreno Valley, CA 92555

Contact Name: Title:

Phone: E-mail:

(4) Please identify the person or persons who serve as the Plan Sponsor's Privacy and Security Official for the HRA Plan. The Privacy and Security Official will be the primary contact for all HIPAA privacy and security matters affecting the Plan.

3. HRA SERVICE MANAGER INTERNAL USE ONLY (to be completed by GBS consultant)

GBS Client Consultant Name:

GBS Office:

Outside Consultant Name (if any):

Attachment C

AMENDED AND RESTATED TRUST AGREEMENT FOR THE VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION POST-EMPLOYMENT HEALTH SAVINGS PLAN

Dated March 1, 2020 by and between County of Riverside and Washington Trust Bank

FEB 11 2020 3.18

AMENDED AND RESTATED
TRUST AGREEMENT FOR THE

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
POST-EMPLOYMENT HEALTH SAVINGS PLAN

Dated March 1, 2020 by and between
County of Riverside, California and Washington Trust Bank

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HIPPA BUSINESS AGREEMENT 21

This Amended and Restated Trust Agreement (this "Agreement" or "Trust" Agreement") is made and entered into this 1st day of March 2020 (the "Effective Date") by and between the County of Riverside (the "County"), a political subdivision of the State of California, and Washington Trust Bank (the "Trustee"), a Washington corporation.

RECITALS

WHEREAS, pursuant to a trust agreement dated and effective as of July 1, 2017 (the "Original Trust Agreement"), the County previously established a trust to hold assets exempt from taxation under Section 501(c)(9) of the Internal Revenue Code for the benefit of employees who are eligible and participate in the Post-Employment Health Savings Plan which is funded by the Employer hereunder; and

WHEREAS, under the Original Trust Agreement the County appointed Washington Trust Bank as Trustee and investment manager of such trust; and

WHEREAS, the County and the Trustee desire to make certain amendments to the Original Trust Agreement; and

WHEREAS, the Trust was originally created and effective as of December 1, 2002, pursuant to the Original Trust Agreement, and shall remain in full force and effect, unless otherwise specifically stated or otherwise modified or terminated in accordance with the provisions of this Trust Agreement, as the same has been or may be amended or restated, and replaces any prior trust agreement in its entirety.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree that the Trustee shall hold all funds and other property from time to time contributed or transferred to it pursuant to the provisions hereof, together with all the increments, proceeds, investments, and reinvestments thereof, and the income therefrom, in trust, for the uses and purposes and upon the terms and conditions hereinafter set forth.

ARTICLE I
DEFINITIONS AND CONSTRUCTION

1.1 Definition. As used in this Agreement, the following terms shall have the meaning hereinafter set out:

(a) "Agreement" shall mean this instrument, as it has been heretofore and may hereafter be amended or restated.

(b) "Code" shall mean the Internal Revenue Code of 1986, as the same has been or may hereafter be amended.

(c) "Employee" shall mean any current or former employee of the Employer.

(d) "Employer" shall mean the County and, individually and collectively, any governmental entity affiliated with the County for purposes of Section 501(c)(9) of the Code that maintains the Plan.

(e) "Member" shall mean any Employee who is a participant in the Plan.

(f) "Plan" shall mean the County of Riverside, California Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan and as such plan may be amended, modified, deleted, supplemented or terminated from time to time, for so long as such plan may be funded through the Trust, in whole or in part.

(g) "Qualified Investment Manager" shall mean an investment manager as defined in Section 3(38) of the Employee Retirement Income Security Act of 1974, and codified at 29 U.S.C. § 1002(38).

(h) "Securities" shall mean common and preferred stocks, contractual obligations of every kind, whether secured or unsecured, equitable interests in real or personal property, and intangible property of every description and howsoever evidenced.

(i) "Taxes" shall mean taxes and shall be deemed to include any interest or penalties assessed in respect to such taxes.

(j) "Trust" shall mean the trust established under the Original Trust Agreement and maintained under this Agreement.

1.2 Construction. Where necessary or appropriate to the meaning thereof, the singular shall be deemed to include the plural, the plural to include the singular, the masculine to include the feminine, the feminine to include the masculine.

ARTICLE II
PURPOSE

2.1 Purpose. The Trust has been established to provide Employees with post-employment medical benefits as set forth in the Plan, while they are eligible to receive such benefits, and to provide such other permissible payments as may be determined from time to time, and it is intended that the benefits and payments provided by the Plan and funded through the Trust be "life, sick, accident, or other benefits" as that phrase is defined in Section 501(c)(9) of the Code.

2.2 Exclusive Benefit. No part of the Trust fund shall be used for purposes other than for (1) the exclusive benefit of Members in accordance with the provisions of the Plan and the Trust, and (2) defraying reasonable expenses of administering the Plan and the Trust.

ARTICLE III
MEMBERSHIP

3.1 Eligibility for Membership. Each Employee who becomes a participant in the Plan shall become a Member as of the date he so becomes a participant. Upon becoming a Member, such Employee shall be bound by all provisions of this Agreement.

3.2 Termination of Membership. An Employee shall cease to be a Member as of the date his participation in the Plan ceases.

ARTICLE IV

FUNDING

4.1 Contributions. The Employer shall contribute to the Trust such amount or amounts, if any, as the County may determine from time to time. All contributions shall be held, administered, and distributed, in trust, under the terms of this Agreement. The Trustee shall not be under any duty to inquire into the timeliness or correctness of the amounts contributed and delivered to the Trustee hereunder; nor shall the Trustee or any other person be under any duty to enforce the payment of the contributions to be made hereunder and the County agrees to indemnify and hold harmless the Trustee in connection therewith. The Trustee shall not be responsible for the calculation or collection of any contributions under or referred to by the Plan and shall have no duties, except as specified under this Agreement, for the administration of the Trust. Nothing in this Agreement shall entitle any Trustee or Member to inquire into or demand the right to inspect the books of Employer. Notwithstanding any provision of this Agreement to the contrary, in no event shall the County be required to continue to fund benefits under any Plan through the Trust.

4.2 Irrevocability of Contributions.

(a) In General. Except as may otherwise be permitted by (i) Section 501(c)(9) of the Code, and (ii) Subsection (b) of this Section 4.2, and as will not result in the imposition of tax under Section 4976 of the Code, all contributions made to the Trust shall be irrevocable.

(b) Mistake of Fact. If a contribution or any portion thereof is made to the Trust due to a good faith mistake of fact, then within one (1) year of the date of payment of such contribution to the Trust an amount equal to the excess of (i) the amount of such contribution, over (ii) the amount which would have been contributed had a mistake of fact not occurred, shall be returned to the contributor. The amount(s) of any contribution(s) to be returned to the Employer in accordance with this subsection shall be limited to Trust assets.

4.3 Trust Fund. The Trustee shall receive the contributions from the County in cash or other property acceptable to it. All assets so received together with the income therefrom and any other increment thereon shall be held, managed, and administered by the Trustee pursuant to the terms hereof as a common fund without distinction between principal and income.

4.4 Set Aside of Income. All income of the Trust shall be set aside and used only for the exempt purposes set forth under Section 501(c)(9) of the Code (including defraying reasonable expenses of administering the Plan and Trust).

ARTICLE V
POWERS AND DUTIES OF THE TRUSTEE

5.1 Trust Property and Investments. In addition to all powers and duties otherwise expressly set forth in this Agreement and subject to the provisions of Section 5.5, the Trustee shall have the following powers:

(a) to invest and reinvest all or any part of the Trust, including both principal and income, in Securities, and other property;

(b) to insure the payment of benefit under a contract or contracts with an insurance company or companies, and hold and retain such contract or contracts as part of the Trust;

(c) to sell, lease, exchange, or otherwise dispose of all or any part of the Trust;

(d) to exercise, buy, or sell rights of conversion or subscription;

(e) to enter into or oppose any plan of consolidation, merger, reorganization, capital readjustment, or liquidation of any corporation or other issuer of Securities held hereunder including any plan for the sale, lease, or mortgage of any of its property or the adjustment or liquidation of any of its indebtedness and, in connection with any such plan, to enter into any other such agreement, and to pay assessments or subscriptions from the other assets held hereunder;

(f) to retain in cash or otherwise in a form unproductive of income such portion of the Trust as is necessitated by the cash requirements of the Plan; provided, however, that, to the extent feasible, such amounts shall be held in forms of investment which are productive of income but are sufficiently liquid to meet such cash requirements;

(g) to deposit Securities held hereunder in any depository;

(h) to deposit all or any part of the Trust, including both principal and interest, in any bank organized under the national banking laws of the United States or under the laws of any State;

(i) to invest in and commingle assets of the Trust in any common or collective trust fund heretofore or hereafter created and administered by the Trustee or its affiliates; provided, however, that, the instrument establishing such common or collective trust fund including all amendments thereto shall govern any investment therein, and is hereby made a part of this Agreement as if fully set forth herein.

The Trustee shall invest Trust assets as directed, in writing by the County. If no such direction is received from the County, the Trustee shall invest Trust assets in one or more of the money market funds generally utilized by the Trustee with respect to its other trust accounts.

The County may appoint one or more Qualified Investment Managers to direct the Trustee with respect to investment of Trust assets, in which case the County shall notify the Trustee of such appointment. In such case, the Qualified Investment Manager shall have the same power to direct the Trustee with respect to such investments as the County had, and the Trustee shall be under no duty to question, and shall not incur any liability on account of following, any direction of the County or Qualified Investment Manager with respect to such investments. The Trustee shall be under no duty to review the

investment guidelines, objectives and restrictions established, or the specific investment instructions given, by the County to such Qualified Investment Manager or to make suggestions to the County in connection therewith.

5.2 Claims Against Trust. Subject to the provisions of Section 5.5, and except as regards benefits under the Plan, the Trustee is empowered to compromise and adjust any and all claims, debts, or obligations in favor of or against the Trust, whether such claims be in litigation or not, and to reduce the rate of interest on, to extend or otherwise modify, or to foreclose upon default, or otherwise enforce any such claim, debt, or obligation.

5.3 Borrowing. Subject to the provisions in Section 5.5, the Trustee is empowered to borrow money in such amounts and upon such terms and conditions as shall be deemed advisable or proper to carry out the purposes of the Trust and to pledge any Securities or other property for the repayment of any such loan; provided, however, no such loan shall be made by the Trustee individually other than a temporary advancement to the Trust on a cash or overdraft basis.

5.4 Registration of Securities; Nominees. The Trustee is empowered to register Securities in its own name, or in the name of its nominee without disclosing the Trust, or to hold the same in bearer form, and to take title to other property in its own name or in the name of its nominee without disclosing the Trust; but the Trustee shall be responsible for the acts of its nominee.

5.5 County Directions. The powers conferred upon the Trustee in Sections 5.1, 5.2, 5.3, and 5.4 shall be exercised by the Trustee in its sole discretion only if and when specifically so authorized in writing by the County. The County shall, at any time and from time to time, certify to the Trustee in writing the name or names of any person authorized to act for the County, with respect to the exercising of any one or more of such powers. Until the County notifies the Trustee that such person is no longer authorized to act for the County, the Trustee may continue to rely on the authorization of such person. The Trustee shall be under no duty or obligation to question any instruction it so receives, except that the Trustee shall have no obligation by reason of any such direction to make any advance or loan in its banking capacity. The Trustee shall have no liability or responsibility for acting without question on the direction of, or failing to act in the absence of any action, unless the Trustee has knowledge that by such action or failure to act it will be participating in or undertaking to conceal a breach of fiduciary duty. The County agrees to indemnify and hold harmless the Trustee for acting or not acting in connection with this Section 5.5; provided, however, that in the event the Trustee is acting in its own discretion, with respect to any assets of the Trust, such indemnification shall be of no effect and the Trustee shall be liable for any breach of fiduciary responsibility in the exercise of its duties under this Agreement and shall indemnify and hold harmless the County for suck breach.

5.6 Agents, Attorneys, Actuaries, and Accountants. The Trustee is empowered to employ such agents, attorneys, actuaries, and accountants as it may deem necessary or proper in connection with its duties hereunder and to determine and pay out of the assets of the

Trust the reasonable compensation and expenses of such agents, attorneys, actuaries, and accountants.

5.7 Other Authority. The Trustee is authorized to execute and deliver any and all instruments and to perform any and all acts which may be necessary or proper to enable it to discharge its duties under this Agreement and to carry out the power and authority conferred upon it.

5.8 Directions to the Trustee. The Trustee may rely on any written direction, request, approval, or other document purporting to have been signed on behalf of the County by the person authorized to act for the County.

5.9 Payment of Taxes. The Trustee is empowered to pay out of the assets of the Trust, as a general charge thereon, any and all Taxes of whatsoever nature assessed on or in respect thereto; provided, however, that if the County shall notify the Trustee in writing that any such Tax is not lawfully or properly assessed, or is questionable, the Trustee, if so requested by the County, shall contest the validity of such Tax in any manner deemed appropriate by the County. Unless the Trustee shall first have been indemnified to its satisfaction by the County, the Trustee shall not be required to contest the validity of any Tax, to institute, maintain, or defend against any other action or proceeding, or to incur any other expense in connection with the Trust, except to the extent that the same is sufficient therefore.

5.10 Compensation and Expenses. The Trustee shall be entitled to such compensation for its service and reimbursement for all reasonable expenses incurred by the Trustee in the administration of the Trust, in accordance with the terms of the HealthInvest Plan Adoption Agreement between the County and the HRA Service Manager or as otherwise agreed in writing between the Trustee and the County. Such compensation and expenses shall be paid from the Trust unless the County, in its discretion, elects to pay such compensation and expenses

5.11 Records and Statements. The Trustee shall keep accurate records of all receipts, disbursements, and other transactions affecting the Trust, which, together with the assets comprising the Trust and all evidences thereof, shall be available during the Trustee's usual business hours for inspection or for the purposes of making copies or reproductions thereof by the County, upon the County's reasonable request. The Trustee shall render to the County monthly statements of receipts, disbursements, and all transactions during the preceding month affecting the Trust. The Trustee further shall render to the County annually a statement of all assets then held by it hereunder.

5.12 Court Action Not Required. All the powers and authority herein conferred upon the Trustee shall be exercised by it without the necessity of applying to any court for leave or confirmation. No person dealing with the Trustee shall be required to ascertain whether the Trustee shall have obtained the approval of any court or of any person to any action

which it may propose to take hereunder, but every such person may rely solely upon the deed, transfer, or assurance of the Trustee.

5.13 Disputes. If a dispute arises as to the payment of any funds or delivery of any assets by the Trustee, the Trustee may withhold such payment or delivery until the dispute is resolved by court of competent jurisdiction or finally settled in writing by the concerned parties.

ARTICLE VI
DISPOSITION OF TRUST ASSETS

6.1 Payments from the Trust. Unless and until the Plan is terminated as therein provided, the Trustee shall make payments from the Trust for the benefit of Members or to pay reasonable expenses of administering the Plan or Trust, as directed by the County or by any administrator appointed by the County.

6.2 No Reversion of Contributions. Except to the extent permitted by Section 4.1 or 4.2, any contribution paid by the County to the Trustee hereunder shall be irrevocable, and it shall be impossible at any time for any part of the Trust's assets to revert to the County or to be used for or diverted to purposes other than for the exclusive benefit of Members or for the payment of Taxes and expenses of administration except to the extent permitted by law. Subject to the foregoing provisions of this Section 6.2, any excess remaining in the Trust upon satisfaction of all liabilities and requirements of the Trustee hereunder shall be disposed of by the Trustee, as directed by the County, for such purposes as shall not adversely affect the exempt status of the Trust under Section 501(c)(9) of the Code, which may include transfer to another trust or trusts exempt from taxation under Section 501(c)(9) of the Code.

ARTICLE VII
SUCCESSION TO THE TRUSTEESHIP

7.1 Resignation of the Trustee. Any Trustee acting hereunder may resign at any time by giving notice in writing to the County at least sixty (60) days before such resignation is to become effective, unless the County shall accept as adequate a shorter notice.

7.2 Removal of the Trustee. The County may remove, with or without cause, any Trustee acting hereunder by giving notice in writing to such Trustee at least thirty (30) days before such removal is to become effective, unless the Trustee shall accept as adequate a shorter notice.

7.3 Appointment of a Successor Trustee. If for any reason a vacancy should occur in the trusteeship, a successor Trustee shall forthwith be appointed by the County by action of duly authorized officer thereof, which successor Trustee may be either a corporation authorized to carry on a trust business or a national banking association. Any successor Trustee appointed hereunder shall execute, acknowledge, and deliver to the County and Trustee an instrument in writing accepting such appointment hereunder. Such successor

Trustee thereupon shall become vested with the same title to the Trust property, and the same powers and duties with respect thereto, as are vested in the original Trustee. The predecessor Trustee shall execute all such instruments and perform all such other acts as the successor Trustee shall reasonably request to effectuate the provisions hereof. The successor Trustee shall have no duty to inquire into the administration of the Trust for any period prior to its succession.

ARTICLE VIII
AMENDMENT AND TERMINATION

8.1 Right of Amendment. Subject to the provisions of Section 8.2, the County reserves the right, by means of a written instrument formally approved by the County's Board of Supervisors and executed in the name of the County to amend the provisions of this Agreement in any manner, provided, however, that the powers and duties of the Trustee shall not be changed without its approval. Any such amendment shall be by written instrument executed by the County and the Trustee. Notwithstanding any provisions of this Section 8.1 to the contrary, any amendment made to this Agreement may be given retroactive effect if in the opinion of the County such amendment is appropriate.

8.2 Limitation on Amendment. The County shall make no amendment to this Agreement which shall permit any part of the Trust property to revert to the Employer or be used for or be diverted to purposes other than the exclusive benefit of Members except to the extent permitted by Section 501(c)(9) of the Code and any other applicable law and as will not result in the imposition of an excise tax under Section 4976 of the Code.

8.3 Right to Terminate. The Employer has the right to terminate its contributions to the Trust. In the event of complete termination of contributions by the Employer, the Employer shall make no further contributions under the Trust, the Trust shall remain in existence, and all of the provisions of the Trust, which, in the opinion of the Trustee are necessary to the purposes of the Trust, shall remain in force, other than the provisions for contributions by the Employer, and all of the assets in the Trust on the date of termination shall be held, administered, and distributed by the Trustee in the manner provided herein and upon final distribution the Trust shall terminate.

8.4 Termination for Breach. The Employer may terminate this Agreement, effective immediately, if Employer, in its sole discretion, determines that Trustee has breached a material provision of this Agreement. Alternatively, Employer may choose to provide Trustee with notice of the existence of an alleged material breach and afford Trustee with an opportunity to cure the alleged material breach and in the event the Trustee fails to cure the breach to the satisfaction of Employer in a timely manner, Employer reserves the right to immediately terminate this Agreement.

ARTICLE IX
INDEMNIFICATION

9.1 Indemnification. Trustee shall indemnify and hold harmless the County of Riverside, its Agencies, Districts, Special Districts and Departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (individually and collectively hereinafter referred to as Indemnitees) from any liability whatsoever, based or asserted upon any services of Trustee, its officers, employees, subcontractor, agents or representatives arising out of or in any way relating to this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Trustee, its officers, employees, subcontractor, agents or representatives Indemnitors from this Agreement. Trustee shall defend, at its sole expense, all costs and fees including, but not limited, to attorney fees, cost of investigation, defense and settlements or awards, the Indemnitees in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by Trustee, Trustee shall, at their sole cost, have the right to use counsel of their own choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of COUNTY; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Trustee's indemnification to Indemnitees as set forth herein.

Trustee's obligation hereunder shall be satisfied when Trustee has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

The specified insurance limits required in this Agreement shall in no way limit or circumscribe Trustee's obligations to indemnify and hold harmless the Indemnitees herein from third party claims.

In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code 2782. Such interpretation shall not relieve the Trustee from indemnifying the Indemnitees to the fullest extent allowed by law.

9.2 Insurance. Without limiting or diminishing the Trustee's (Washington Trust Bank, the "Trustee") obligation to indemnify or hold the County harmless, Trustee shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverages during the term of this Agreement. As respects to the insurance Section only, the County herein refers to the County of Riverside, its Agencies, Districts, Special Districts, and Departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insureds.

A. Workers' Compensation:

If the Trustee has employees as defined by the State of California, the Trustee shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than $1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside.

B. Commercial General Liability:

Commercial General Liability insurance coverage, including but not limited to, premises liability, unmodified contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage, covering claims which may arise from or out of Trustee's performance of its obligations hereunder. Policy shall name the County as Additional Insured. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

C. Vehicle Liability:

If vehicles or mobile equipment are used in the performance of the obligations under this Agreement, then Trustee shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit. Policy shall name the County as Additional Insureds.

D. Professional Liability:

Trustee shall maintain Professional Liability Insurance providing coverage for the Trustee's performance of work included within this Agreement, with a limit of liability of not less than $1,000,000 per occurrence and $2,000,000 annual aggregate. If Trustee's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this Agreement and Trustee shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also, known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that Trustee has maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2), or 3) will continue as long as the law allows.

E. Insurance Requirements for IT Trustee Services:

Trustee shall procure and maintain for the duration of the contract insurance against claims for injuries to person or damages to property which may arise from or in connection with the performance of the work hereunder by the Trustee, its agents, representatives, or

employees. Trustee shall procure and maintain for the duration of the contract insurance claims arising out of their services and including, but not limited to loss, damage, theft or other misuse of data, infringement of intellectual property, invasion of privacy and breach of data.

Cyber Liability Insurance, with limits not less than $2,000,000 per occurrence or claim, $2,000,000 aggregate. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by Trustee in this agreement and shall include, but not limited to, claims involving infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall provide coverage for breach response costs as well as regulatory fines and penalties as well as credit monitoring expenses with limits sufficient to respond to these obligations.

If the Trustee maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or higher limits maintained by the Trustee. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the County.

F. General Insurance Provisions - All lines:

1) Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California and have an AM BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by the County Risk Manager. If the County's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.

2) The Trustee must declare its insurance self-insured retention for each coverage required herein. If any such self-insured retention exceed $500,000 per occurrence each such retention shall have the prior written consent of the County Risk Manager before the commencement of operations under this Agreement. Upon notification of self-insured retention unacceptable to the County, and at the election of the County's Risk Manager, Trustee's carriers shall either; 1) reduce or eliminate such self-insured retention as respects this Agreement with the County, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3) Trustee shall cause Trustee's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and certified original copies of Endorsements effecting coverage as required herein, and 2) if requested to do so orally or in writing by the County Risk Manager, provide original Certified copies of policies including all Endorsements and all attachments thereto, showing such insurance is in full force and effect. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that a minimum of ten

(10) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. If Trustee insurance carrier(s) policies does not meet the minimum notice requirement found herein, Trustee shall cause Trustee's insurance carrier(s) to furnish a 30 day Notice of Cancellation Endorsement.

4) In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. Trustee shall not commence operations until the County has been furnished original Certificate (s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.

5) It is understood and agreed to by the parties hereto that the Trustee's insurance shall be construed as primary insurance, and the County's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

6) If, during the term of this Agreement or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work; or, the term of this Agreement, including any extensions thereof, exceeds five (5) years; the County reserves the right to adjust the types of insurance and the monetary limits of liability required under this Agreement, if in the County Risk Management's reasonable judgment, the amount or type of insurance carried by the Trustee has become inadequate.

7) Trustee shall pass down the insurance obligations contained herein to all tiers of subcontractors working under this Agreement.

8) The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the County.

9) Trustee agrees to notify County of any claim by a third party or any incident or event that may give rise to a claim arising from the performance of this Agreement.

ARTICLE X
MISCELLANEOUS

10.1 Validity of Agreement. The validity of this Agreement shall be determined and this Agreement shall be construed and interpreted in accordance with the laws of the State of California. If any provision of this Agreement is held to be illegal or invalid for any

reason and such illegality or invalidity prevents the accomplishment of the objectives and purposes of the Trust, in the event of any such holding, the parties may immediately, and if in accordance with appropriate law retroactively, amend the Agreement as is necessary to remedy any such defect.

10.2 No Guarantees. Neither the Employer nor the Trustee guarantees the Trust from loss or depreciation, nor the payment of any amount which may become due to any person hereunder. Nothing contained in the Trust shall constitute a guarantee by the Employer, the County or the Trustee that the assets of the Trust will be sufficient to pay any benefit to any person or make any other payment. Payments to be paid from the Trust are limited to the assets remaining in the Trust at the time payment is made. Prior to the time that distributions are made in conformity with the Plan and the Trust, Members or other persons shall not receive any distribution of cash or other thing of current or exchangeable value, either from the Employer, the County, or the Trustee on account of, or as a result of the Trust fund created hereunder.

10.3 Duty to Furnish Information. The County and the Trustee each shall furnish to the other any documents, reports, returns, statements, or other information that the other reasonably deems necessary to perform its duties imposed under any Plan or this Agreement or otherwise imposed by law. The County shall have the right to conduct an audit of Trust income, expenses, investments, and accounts or to have such audit conducted by an audit firm of its choosing. Similarly, Trust records shall be available for inspection and review by any regulatory agencies authorized by law to do so. The Trustee, Employer and Qualified Investment Manager and all persons and entities retained by any of them to perform services with respect to the Trust shall (a) cooperate with any such audit, inspection or review, and (b) retain any records within their possession pertaining to the Trust for a period of at least five (5) years unless they first offer to turn over such records to the County prior to disposing of such records. This Section 10.3 shall survive the termination of this document and the termination of the Trust.

10.4 Taxes. The Trustee shall withhold any Tax which by any present or future law is required to be withheld from any payment to any Member hereunder.

10.5 Commingled Trust Fund. The fact that separate records may be maintained by the County or Trustee or any other person for each Member or group thereof, shall not be deemed to segregate for or give to such Member or group thereof, any direct interest in any specific assets of the Trust.

10.6 Rebates and Adjustments. Notwithstanding any provisions of this Trust to the contrary, the County may, in its discretion and to the extent permitted by Section 501(c)(9) of the Code and as would not result in the imposition of tax under Section 4976 of the Code, direct the Trustee to make administrative adjustments strictly incidental to the providing of benefits to Members. In addition, in the event a benefit is provided or a disbursement is made from the Trust as a result of a directive from the County (or its appointee) and it is determined by the County (or its appointee) that such benefit should not have been

provided or disbursement made, the County may make a contribution to reimburse the Trust or engage in efforts to seek the return of the benefit or disbursement. The Trustee shall be under no duty or obligation to inquire into the correctness of any determination made by the County resulting in a direction to the Trustee under this provision.

10.7 Specific Accounts. At no time shall any segregated account or separate fund be considered a savings account or investment or asset of any particular Member or group thereof, and no Member or group thereof shall have any right to any particular asset which the County or the Trustee may have allocated to any segregated account or separate fund for accounting purposes.

10.8 Inalienability of Benefits. Except as may otherwise be provided herein, the right of any Member or other person or entity to any benefit or payment from the Trust shall not be subject to voluntary or involuntary transfer, alienation, pledge, assignment or other disposition and shall not be subject to attachment, execution, garnishment, sequestration or other legal or equitable process. Any attempt to transfer, alienate, pledge, assign, or otherwise dispose of such right or any attempt to subject such right to attachment, execution, garnishment, sequestration or other legal or equitable process shall be null and void, unless such action is (i) approved by the County (or its appointee); and (ii) undertaken in accordance with the terms and provisions of the Plan and the Trust.

10.9 No Implied Rights. Neither the establishment of the Trust nor any modification thereof, nor the creation of any fund, trust or account thereunder, shall be construed as giving any Member or other person or entity any legal or equitable right unless such right shall be specifically provided for in the Plan and the Trust or conferred by affirmative action of the County in accordance with the express written terms and provisions of the Plan and the Trust.

10.10 Status of Employment Relations. The adoption and maintenance of the Trust shall not be deemed to constitute a contract between the Employer and its Employees or any representative thereof or to be consideration for, or an inducement or condition of, the employment of any person. Nothing contained herein shall be deemed to:

(a) give to any Employee the right to be retained in the employment of the Employer;
(b) affect the right of the Employer to discipline or discharge any Employee at any time; or
(c) affect any Employee's right to terminate his employment at any time.

10.11 Uniform Application. The County shall apply the provisions and any rules, regulations and conditions adopted by it (or its appointee) in a uniform and nondiscriminatory manner in accordance with Sections 505 and 501(c)(9) of the Code, so that all persons similarly situated shall be similarly treated. In addition, all rules, regulations and conditions adopted by it must be reasonably related to the type or amount of benefit or other payment provided under the Trust and must be objectively selected and administered so as to not provide disproportionate benefits in favor of officers or highly

compensated employees of the Employer or highly compensated individuals (in accordance with Sections 501(c)(9) and 505 of the Code).

10.12 Parties Bound. This Agreement shall be binding upon the parties hereto, all Employees and, as the case may be, the heirs, executors, administrators, successors, and assigns of each of them.

10.13 Governing Law and Venue. This Agreement will be governed, enforced, and interpreted in accordance with the laws of the State of California, except where federal law preempts state law. The venue and jurisdiction for any action arising under this Agreement will be in the state or federal courts in Riverside, California. The parties consent to the jurisdiction and venue of the state or federal courts in Riverside, California and waive any objections to such jurisdiction and venue. The parties consent to the jurisdiction and venue of the state or federal courts in California and waive any objections to such jurisdiction and venue.

10.14 Entire Agreement. This Agreement (together will all attachments hereto) shall constitute the entire agreement between the parties related to the rights herein granted and the obligations herein assumed. It is the express intention of the Trustee and the County that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Trust Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

10.15 Delivery of Notices. Any notice or other communication provided for in this Agreement will be given in writing, delivered to the respective parties at the addresses set forth below or to such other address(es) as the parties may hereafter designate, and are deemed to be submitted (1) day after the deposit to the United States Postal Service or private courier if delivered by U.S. Postal Services express delivery or overnight courier that guarantees next day delivery, or five (5) days after their deposit in the United States mail, postage prepaid:

If to the Trustee:

Washington Trust Bank
c/o Steve R. Sherman
Re: County of Riverside Voluntary Employees' Beneficiary Association (VEBA)
Post Employment Program (PEP) Health Savings Plan (HSP)
717 W. Sprague Ave
Spokane, WA 99201

If to the County:

County of Riverside
c/o Human Resources Division
4080 Lemon St. 1st Floor
Riverside, CA 92502-1569

10.16 Severability. In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force and effect without being impaired or invalidated in any way.

10.17 Government Claims Act. The provisions of the Government Claims Act (California Government Code Section 900 et seq.) must be followed first for any disputes under this Agreement.

10.18 Independent Trustee. The relationship between County and Trustee is an independent Trustee relationship. Neither County nor its employee(s) and/or agent(s) shall be considered to be an employee(s), and/or agent(s) of Trustee. Neither Trustee nor any employee(s) and/or agent(s) of Trustee shall be considered to be an employee(s) and/or agent(s) of County. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

10.19 Waiver. Any waiver by either party of any breach of any one or more of the terms of this Agreement shall not be construed to be a waiver of any subsequent or other breach of the same term or of any other term herein.

10.20 Conflict of Interest. The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

10.21. Force Majeure. In case by reason of force majeure either party hereto shall be rendered unable wholly or in part to carry out its obligations under this Agreement, then except as otherwise expressly provided in this Agreement, if such party shall give notice and full particulars of such force majeure in writing to the other party within a reasonable time after occurrence of the event or cause relied on, the obligations of the party giving such notice (other than the obligations pertaining to Insurance, Section 9.2 herein, or Indemnification, Section 9.1 herein), so far as they are affected by such force majeure, shall be suspended during the continuance of the inability then claimed which shall include a reasonable time for the removal of the effect thereof, but for no longer period, and such party shall endeavor to remove or overcome such inability with all reasonable dispatch. The term "force majeure," as employed herein, shall mean any cause beyond the reasonable control of the party asserting force majeure and shall include, but shall not be limited to, labor disputes or other industrial disturbances, systemic electrical, telecommunications or other utility failures, earthquakes, hurricanes, tornadoes or other acts of nature, embargoes, riots, acts or orders of government, acts of terrorism or war."

10.22. Interpretation. The parties to this Agreement and their counsel have reviewed and revised this Agreement, and the normal rule of construction to the effect that any ambiguities in an agreement are to be resolved against the drafting parties shall not be employed in the interpretation of this Agreement.

10.23. Counterparts. This Agreement may be executed in several counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument

IN WITNESS WHEREOF, the parties hereto have caused their duly appointed representatives to execute this Trust Agreement effective as of the effected date March 1, 2020.

Each party certifies that the individuals signing below has the authority to execute this Agreement on behalf of such party and may legally bind such party to the terms and conditions of the Agreement, including any attachments hereto.

ATTEST:
Clerk of the Board
Kecia R. Harper

By: _____
Deputy

Date: FEB 11 2020

COUNTY OF RIVERSIDE:

By: _____
V. Manuel Perez
Chairman, Board of Supervisors

Date: FEB 11 2020

Approved as to Form:
Gregory P. Priamos
County Counsel

By: _____
Chief Deputy County Counsel
SYNTHIA M. GUNZEL

ATTEST:

_____

_____

WASHINGTON TRUST BANK, a trust bank chartered under the laws of the State of Washington

By: _____

Name: Steve Sherman

Title: Vice President

Date: 1-24-2020

By: _____

Name: Rob Blume

Title: Senior Vice President

Date: 01/24/2020

HIPAA Business Associate Agreement
Addendum to Contract
Between the County of Riverside and Washington Trust Bank

This HIPAA Business Associate Agreement (the "Addendum") supplements, and is made part of the Trust Agreement for the Voluntary Employees' Beneficiary Association Post-Employment Health Savings Plan ("the Underlying Agreement") between the County of Riverside ("County") a political subdivision of the State of California, and Washington Trust Bank ("Trustee") a Washington corporation, and shall be effective as of the date the Underlying Agreement is approved by both Parties (the "Effective Date").

RECITALS

WHEREAS, County and Trustee entered into the Underlying Agreement pursuant to which the Trustee provides services to County, and in conjunction with the provision of such services certain protected health information ("PHI") and/or certain electronic protected health information ("ePHI") may be created by or made available to Trustee for the purposes of carrying out its obligations under the Underlying Agreement; and,

WHEREAS, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191 enacted August 21, 1996, and the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time, are applicable to the protection of any use or disclosure of PHI and/or ePHI pursuant to the Underlying Agreement; and,

WHEREAS, County is a covered entity, as defined in the Privacy Rule; and,

WHEREAS, to the extent County discloses PHI and/or ePHI to Trustee or Trustee creates, receives, maintains, transmits, or has access to PHI and/or ePHI of County, Trustee is a business associate, as defined in the Privacy Rule; and,

WHEREAS, pursuant to 42 USC §17931 and §17934, certain provisions of the Security Rule and Privacy Rule apply to a business associate of a covered entity in the same manner that they apply to the covered entity, the additional security and privacy requirements of HITECH are applicable to business associates and must be incorporated into the business associate agreement, and a business associate is liable for civil and criminal penalties for failure to comply with these security and/or privacy provisions; and,

WHEREAS, the parties mutually agree that any use or disclosure of PHI and/or ePHI must be in compliance with the Privacy Rule, Security Rule, HIPAA, HITECH and any other applicable law; and,

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply

to Trustee as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Trustee during the course of performing functions, services and activities on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HITECH, HIPAA, Security Rule and/or Privacy Rule, as may be amended from time to time.

1.

A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402.

(a)

(1) Except as provided below in Paragraph (2) of this definition, acquisition, access, use, or disclosure of PHI in a manner not permitted by subpart E of the Privacy Rule is presumed to be a breach unless Trustee demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following four factors:

(b)

(c) (a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

(d)

(e) (b) The unauthorized person who used the PHI or to whom the disclosure was made;

(f)

(g) (c) Whether the PHI was actually acquired or viewed; and

(h)

B. (d) The extent to which the risk to the PHI has been mitigated.

C. (2) Breach excludes:

(1) (a) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of the Privacy Rule.

(2) (b) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate, or organized health care arrangement in which County participates, and the information received as a result of such disclosure

is not further used or disclosed in a manner not permitted by subpart E of the Privacy Rule.

(3) (c) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

B. "Business associate" has the meaning given such term in 45 CFR §164.501, including but not limited to a subcontractor that creates, receives, maintains, transmits or accesses PHI on behalf of the business associate.

C. "Data aggregation" has the meaning given such term in 45 CFR §164.501.

D. "Designated record set" as defined in 45 CFR §164.501 means a group of records maintained by or for a covered entity that may include: the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or, used, in whole or in part, by or for the covered entity to make decisions about individuals.

E. "Electronic protected health information" ("ePHI") as defined in 45 CFR §160.103 means protected health information transmitted by or maintained in electronic media.

F. "Electronic health record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given such term in 42 USC §17921(5).

G. "Health care operations" has the meaning given such term in 45 CFR §164.501.

H. "Individual" as defined in 45 CFR §160.103 means the person who is the subject of protected health information.

I. "Person" as defined in 45 CFR §160.103 means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

J. "Privacy Rule" means the HIPAA regulations codified at 45 CFR Parts 160 and 164, Subparts A and E.

K. "Protected health information" ("PHI") has the meaning given such term in 45 CFR §160.103, which includes ePHI.

L. "Required by law" has the meaning given such term in 45 CFR §164.103.

M. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS").

N. "Security incident" as defined in 45 CFR §164.304 means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. "Security Rule" means the HIPAA Regulations codified at 45 CFR Parts 160 and 164, Subparts A and C.

P. "Subcontractor" as defined in 45 CFR §160.103 means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

Q. "Unsecured protected health information" and "unsecured PHI" as defined in 45 CFR §164.402 means PHI not rendered unusable, unreadable, or indecipherable to unauthorized persons through use of a technology or methodology specified by the Secretary in the guidance issued under 42 USC §17932(h)(2).

2. **Scope of Use and Disclosure by Trustee of County's PHI and/or ePHI.**

A. Except as otherwise provided in this Addendum, Trustee may use, disclose, or access PHI and/or ePHI as necessary to perform any and all obligations of Trustee under the Underlying Agreement or to perform functions, activities or services for, or on behalf of, County as specified in this Addendum, if such use or disclosure does not violate HIPAA, HITECH, the Privacy Rule and/or Security Rule.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, in accordance with 45 CFR §164.504(e)(2), Trustee may:

1) Use PHI and/or ePHI if necessary for Trustee's proper management and administration and to carry out its legal responsibilities; and,

2) Disclose PHI and/or ePHI for the purpose of Trustee's proper management and administration or to carry out its legal responsibilities, only if:

a) The disclosure is required by law; or,

b) Trustee obtains reasonable assurances, in writing, from the person to whom Trustee will disclose such PHI and/or ePHI that the person will:

i. Hold such PHI and/or ePHI in confidence and use or further disclose it only for the purpose for which Trustee disclosed it to the person, or as required by law; and,

ii. Notify County of any instances of which it becomes aware in which the confidentiality of the information has been breached; and,

3) Use PHI to provide data aggregation services relating to the health care operations of County pursuant to the Underlying Agreement or as requested by County; and,

4) De-identify all PHI and/or ePHI of County received by Trustee under this Addendum provided that the de-identification conforms to the requirements of the Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

C. Notwithstanding the foregoing, in any instance where applicable state and/or federal laws and/or regulations are more stringent in their requirements than the provisions of HIPAA, including, but not limited to, prohibiting disclosure of mental health and/or substance abuse records, the applicable state and/or federal laws and/or regulations shall control the disclosure of records.

3. **Prohibited Uses and Disclosures.**

A. Trustee may neither use, disclose, nor access PHI and/or ePHI in a manner not authorized by the Underlying Agreement or this Addendum without patient authorization or de-identification of the PHI and/or ePHI and as authorized in writing from County.

B. Trustee may neither use, disclose, nor access PHI and/or ePHI it receives from County or from another business associate of County, except as permitted or required by this Addendum, or as required by law.

C. Trustee agrees not to make any disclosure of PHI and/or ePHI that County would be prohibited from making.

D. Trustee shall not use or disclose PHI for any purpose prohibited by the Privacy Rule, Security Rule, HIPAA and/or HITECH, including, but not limited to 42 USC §17935 and §17936. Trustee agrees:

1) Not to use or disclose PHI for fundraising , unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.514(f) or 45 CFR §164.508;

2) Not to use or disclose PHI for marketing, as defined in 45 CFR §164.501, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.508(a)(3);

3) Not to disclose PHI, except as otherwise required by law, to a health plan for purposes of carrying out payment or health care operations, if the individual has requested this restriction pursuant to 42 USC §17935(a) and 45 CFR §164.522, and has paid out of pocket in full for the health care item or service to which the PHI solely relates; and,

4) Not to receive, directly or indirectly, remuneration in exchange for PHI, or engage in any act that would constitute a sale of PHI, as defined in 45 CFR §164.502(a)(5)(ii), unless permitted by the Underlying Agreement and in compliance with the requirements of a valid authorization under 45 CFR

§164.508(a)(4). This prohibition shall not apply to payment by County to Trustee for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

A. County agrees to make its best efforts to notify Trustee promptly in writing of any restrictions on the use or disclosure of PHI and/or ePHI agreed to by County that may affect Trustee's ability to perform its obligations under the Underlying Agreement, or this Addendum.

B. County agrees to make its best efforts to promptly notify Trustee in writing of any changes in, or revocation of, permission by any individual to use or disclose PHI and/or ePHI, if such changes or revocation may affect Trustee's ability to perform its obligations under the Underlying Agreement, or this Addendum.

C. County agrees to make its best efforts to promptly notify Trustee in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect Trustee's use or disclosure of PHI and/or ePHI.

D. County agrees not to request Trustee to use or disclose PHI and/or ePHI in any manner that would not be permissible under HITECH, HIPAA, the Privacy Rule, and/or Security Rule.

E. County agrees to obtain any authorizations necessary for the use or disclosure of PHI and/or ePHI, so that Trustee can perform its obligations under this Addendum and/or Underlying Agreement.

5. **Obligations of Trustee.** In connection with the use or disclosure of PHI and/or ePHI, Trustee agrees to:

A. Use or disclose PHI only if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e). Trustee shall also comply with the additional privacy requirements that are applicable to covered entities in HITECH, as may be amended from time to time.

B. Not use or further disclose PHI and/or ePHI other than as permitted or required by this Addendum or as required by law. Trustee shall promptly notify County if Trustee is required by law to disclose PHI and/or ePHI.

C. Use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

D. Mitigate, to the extent practicable, any harmful effect that is known to Trustee of a use or disclosure of PHI and/or ePHI by Trustee in violation of this Addendum.

E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or

Security Rule of which Trustee becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410.

F. In accordance with 45 CFR §164.502(e)(1)(ii), require that any subcontractors that create, receive, maintain, transmit or access PHI on behalf of the Trustee agree through contract to the same restrictions and conditions that apply to Trustee with respect to such PHI and/or ePHI, including the restrictions and conditions pursuant to this Addendum.

G. Make available to County or the Secretary, in the time and manner designated by County or Secretary, Trustee's internal practices, books and records relating to the use, disclosure and privacy protection of PHI received from County, or created or received by Trustee on behalf of County, for purposes of determining, investigating or auditing Trustee's and/or County's compliance with the Privacy Rule.

H. Request, use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the request, use or disclosure in accordance with 42 USC §17935(b) and 45 CFR §164.502(b)(1).

I. Comply with requirements of satisfactory assurances under 45 CFR §164.512 relating to notice or qualified protective order in response to a third party's subpoena, discovery request, or other lawful process for the disclosure of PHI, which Trustee shall promptly notify County upon Trustee's receipt of such request from a third party.

J. Not require an individual to provide patient authorization for use or disclosure of PHI as a condition for treatment, payment, enrollment in any health plan (including the health plan administered by County), or eligibility of benefits, unless otherwise excepted under 45 CFR §164.508(b)(4) and authorized in writing by County.

K. Use appropriate administrative, technical and physical safeguards to prevent inappropriate use, disclosure, or access of PHI and/or ePHI.

L. Obtain and maintain knowledge of applicable laws and regulations related to HIPAA and HITECH, as may be amended from time to time.

M. Comply with the requirements of the Privacy Rule that apply to the County to the extent Trustee is to carry out County's obligations under the Privacy Rule.

N. Take reasonable steps to cure or end any pattern of activity or practice of its subcontractor of which Trustee becomes aware that constitute a material breach or violation of the subcontractor's obligations under the business associate contract with Trustee, and if such steps are unsuccessful, Trustee agrees to terminate its contract with the subcontractor if feasible.

6. **Access to PHI, Amendment and Disclosure Accounting.** Trustee agrees to:

A. **Access to PHI, including ePHI.** Provide access to PHI, including ePHI if maintained electronically, in a designated record set to County or an individual as directed by County, within five (5) days of request from County, to satisfy the requirements of 45 CFR §164.524.

B. **Amendment of PHI.** Make PHI available for amendment and incorporate amendments to PHI in a designated record set County directs or agrees to at the request of an individual, within fifteen (15) days of receiving a written request from County, in accordance with 45 CFR §164.526.

C. **Accounting of disclosures of PHI and electronic health record.** Assist County to fulfill its obligations to provide accounting of disclosures of PHI under 45 CFR §164.528 and, where applicable, electronic health records under 42 USC §17935(c) if Trustee uses or maintains electronic health records. Trustee shall:

1) Document such disclosures of PHI and/or electronic health records, and information related to such disclosures, as would be required for County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record in accordance with 45 CFR §164.528.

2) Within fifteen (15) days of receiving a written request from County, provide to County or any individual as directed by County information collected in accordance with this section to permit County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record.

3) Make available for County information required by this Section 6.C for six (6) years preceding the individual's request for accounting of disclosures of PHI, and for three (3) years preceding the individual's request for accounting of disclosures of electronic health record.

7. **Security of ePHI.** In the event County discloses ePHI to Trustee or Trustee needs to create, receive, maintain, transmit or have access to County ePHI, in accordance with 42 USC §17931 and 45 CFR §164.314(a)(2)(i), and §164.306, Trustee shall:

A. Comply with the applicable requirements of the Security Rule, and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that Trustee creates, receives, maintains, or transmits on behalf of County in accordance with 45 CFR §164.308, §164.310, and §164.312;

B. Comply with each of the requirements of 45 CFR §164.316 relating to the implementation of policies, procedures and documentation requirements with respect to ePHI;

C. Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;

D. Protect against any reasonably anticipated uses or disclosures of ePHI that are not permitted or required under the Privacy Rule;

E. Ensure compliance with the Security Rule by Trustee's workforce;

F. In accordance with 45 CFR §164.308(b)(2), require that any subcontractors that create, receive, maintain, transmit, or access ePHI on behalf of Trustee agree through contract to the same restrictions and requirements contained in this Addendum and comply with the applicable requirements of the Security Rule;

G. Report to County any security incident of which Trustee becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410; and,

H. Comply with any additional security requirements that are applicable to covered entities in Title 42 (Public Health and Welfare) of the United States Code, as may be amended from time to time, including but not limited to HITECH.

8. **Breach of Unsecured PHI.** In the case of breach of unsecured PHI, Trustee shall comply with the applicable provisions of 42 USC §17932 and 45 CFR Part 164, Subpart D, including but not limited to 45 CFR §164.410.

A. **Discovery and notification.** Following the discovery of a breach of unsecured PHI, Trustee shall notify County in writing of such breach without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, except as provided in 45 CFR §164.412.

1) **Breaches treated as discovered.** A breach is treated as discovered by Trustee as of the first day on which such breach is known to Trustee or, by exercising reasonable diligence, would have been known to Trustee, which includes any person, other than the person committing the breach, who is an employee, officer, or other agent of Trustee (determined in accordance with the federal common law of agency).

2) **Content of notification.** The written notification to County relating to breach of unsecured PHI shall include, to the extent possible, the following information if known (or can be reasonably obtained) by Trustee:

a) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Trustee to have been accessed, acquired, used or disclosed during the breach;

b) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

c) A description of the types of unsecured PHI involved in the breach, such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved;

d) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

e) A brief description of what Trustee is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and,

f) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

B. **Cooperation.** With respect to any breach of unsecured PHI reported by Trustee, Trustee shall cooperate with County and shall provide County with any information requested by County to enable County to fulfill in a timely manner its own reporting and notification obligations, including but not limited to providing notice to individuals, prominent media outlets and the Secretary in accordance with 42 USC §17932 and 45 CFR §164.404, §164.406 and §164.408.

C. **Breach log.** To the extent breach of unsecured PHI involves less than 500 individuals, Trustee shall maintain a log or other documentation of such breaches and provide such log or other documentation on an annual basis to County not later than fifteen (15) days after the end of each calendar year for submission to the Secretary.

D. **Delay of notification authorized by law enforcement.** If Trustee delays notification of breach of unsecured PHI pursuant to a law enforcement official's statement that required notification, notice or posting would impede a criminal investigation or cause damage to national security, Trustee shall maintain documentation sufficient to demonstrate its compliance with the requirements of 45 CFR §164.412.

E. **Payment of costs.** With respect to any breach of unsecured PHI caused solely by the Trustee's failure to comply with one or more of its obligations under this Addendum and/or the provisions of HITECH, HIPAA, the Privacy Rule or the Security Rule, Trustee agrees to pay any and all costs associated with providing all legally required notifications to individuals, media outlets, and the Secretary. This provision shall not be construed to limit or diminish Trustee's obligations to indemnify, defend and hold harmless County under Section 9 of this Addendum.

F. **Documentation.** Pursuant to 45 CFR §164.414(b), in the event Trustee's use or disclosure of PHI and/or ePHI violates the Privacy Rule, Trustee shall maintain documentation sufficient to demonstrate that all notifications were made by Trustee as required by 45 CFR Part 164, Subpart D, or that such use or disclosure did not constitute a breach, including Trustee's completed risk assessment and investigation documentation.

G. **Additional State Reporting Requirements.** The parties agree that this Section 8.G applies only if and/or when County, in its capacity as a licensed clinic, health

facility, home health agency, or hospice, is required to report unlawful or unauthorized access, use, or disclosure of medical information under the more stringent requirements of California Health & Safety Code §1280.15. For purposes of this Section 8.G, "unauthorized" has the meaning given such term in California Health & Safety Code §1280.15(j)(2).

1) Trustee agrees to assist County to fulfill its reporting obligations to affected patients and to the California Department of Public Health ("CDPH") in a timely manner under the California Health & Safety Code §1280.15.

2) Trustee agrees to report to County any unlawful or unauthorized access, use, or disclosure of patient's medical information without unreasonable delay and no later than two (2) business days after Trustee detects such incident. Trustee further agrees such report shall be made in writing, and shall include substantially the same types of information listed above in Section 8.A.2 (Content of Notification) as applicable to the unlawful or unauthorized access, use, or disclosure as defined above in this section, understanding and acknowledging that the term "breach" as used in Section 8.A.2 does not apply to California Health & Safety Code §1280.15.

9. **Hold Harmless/Indemnification.**

A. Trustee agrees to indemnify and hold harmless County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Trustee, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Addendum, including but not limited to property damage, bodily injury, death, or any other element of any kind or nature whatsoever arising from the performance of Trustee, its officers, agents, employees, subcontractors, agents or representatives from this Addendum. Trustee shall defend, at its sole expense, all costs and fees, including but not limited to attorney fees, cost of investigation, defense and settlements or awards, of County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents or representatives in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by Trustee, Trustee shall, at their sole cost, have the right to use counsel of their choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Trustee's indemnification to County as set forth herein. Trustee's obligation to defend, indemnify and hold harmless County shall be subject to County having given Trustee written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and

reasonable assistance, at Trustee's expense, for the defense or settlement thereof. Trustee's obligation hereunder shall be satisfied when Trustee has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Addendum shall in no way limit or circumscribe Trustee's obligations to indemnify and hold harmless County herein from third party claims arising from issues of this Addendum.

D. In the event there is conflict between this clause and California Civil Code §2782, this clause shall be interpreted to comply with Civil Code §2782. Such interpretation shall not relieve the Trustee from indemnifying County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Addendum, this indemnification shall only apply to the subject issues included within this Addendum.

10. **Term.** This Addendum shall commence upon the Effective Date and shall terminate when all PHI and/or ePHI provided by County to Trustee, or created or received by Trustee on behalf of County, is destroyed or returned to County, or, if it is infeasible to return or destroy PHI and/ePHI, protections are extended to such information, in accordance with section 11.B of this Addendum.

11. **Termination.**

A. **Termination for Breach of Contract.** A breach of any provision of this Addendum by either party shall constitute a material breach of the Underlying Agreement and will provide grounds for terminating this Addendum and the Underlying Agreement with or without an opportunity to cure the breach, notwithstanding any provision in the Underlying Agreement to the contrary. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

1) Terminate the Underlying Agreement and this Addendum, effective immediately, if the other party breaches a material provision of this Addendum.

2) Provide the other party with an opportunity to cure the alleged material breach and in the event the other party fails to cure the breach to the satisfaction of the non-breaching party in a timely manner, the non-breaching party has the right to immediately terminate the Underlying Agreement and this Addendum.

3) If termination of the Underlying Agreement is not feasible, the breaching party, upon the request of the non-breaching party, shall implement, at its own expense, a plan to cure the breach and report regularly on its compliance with such plan to the non-breaching party.

B. **Effect of Termination.**

1) Upon termination of this Addendum, for any reason, Trustee shall return or, if agreed to in writing by County, destroy all PHI and/or ePHI received from County, or created or received by the Trustee on behalf of County, and, in the event of destruction, Trustee shall certify such destruction, in writing, to County. This provision shall apply to all PHI and/or ePHI which are in the possession of subcontractors or agents of Trustee. Trustee shall retain no copies of PHI and/or ePHI, except as provided below in paragraph (2) of this section.
2) In the event that Trustee determines that returning or destroying the PHI and/or ePHI is not feasible, Trustee shall provide written notification to County of the conditions that make such return or destruction not feasible. Upon determination by Trustee that return or destruction of PHI and/or ePHI is not feasible, Trustee shall extend the protections of this Addendum to such PHI and/or ePHI and limit further uses and disclosures of such PHI and/or ePHI to those purposes which make the return or destruction not feasible, for so long as Trustee maintains such PHI and/or ePHI.

12. **General Provisions.**

A. **Retention Period.** Whenever Trustee is required to document or maintain documentation pursuant to the terms of this Addendum, Trustee shall retain such documentation for 6 years from the date of its creation or as otherwise prescribed by law, whichever is later.

D.

B. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for County to comply with HITECH, the Privacy Rule, Security Rule, and HIPAA generally.

C. **Survival.** The obligations of Trustee under Sections 3, 5, 6, 7, 8, 9, 11.B and 12.A of this Addendum shall survive the termination or expiration of this Addendum.

D. **Regulatory and Statutory References.** A reference in this Addendum to a section in HITECH, HIPAA, the Privacy Rule and/or Security Rule means the section(s) as in effect or as amended.

E. **Conflicts.** The provisions of this Addendum shall prevail over any provisions in the Underlying Agreement that conflict or appear inconsistent with any provision in this Addendum.

F. **Interpretation of Addendum.**

1) This Addendum shall be construed to be part of the Underlying Agreement as one document. The purpose is to supplement the Underlying Agreement to include the requirements of the Privacy Rule, Security Rule, HIPAA and HITECH.
2) Any ambiguity between this Addendum and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, Security Rule, HIPAA and HITECH generally.

G. **Notices to County.** All notifications required to be given by Trustee to County pursuant to the terms of this Addendum shall be made in writing and delivered to the County both by fax and to both of the addresses listed below by either registered or certified mail return receipt requested or guaranteed overnight mail with tracing capability, or at such other address as County may hereafter designate. All notices to County provided by Trustee pursuant to this Section shall be deemed given or made when received by County.

County HIPAA Privacy Officer: HIPAA Privacy Manager

County HIPAA Privacy Officer Address:26520 Cactus Avenue, Moreno Valley, CA 92555

County HIPAA Privacy Officer Phone Number: (951) 486-6471

Attachment D

HealthInvest HRA
PLAN ADOPTION AGREEMENT

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HealthInvest HRA

PLAN ADOPTION AGREEMENT

1. **Formal Authorization and Adoption of Plan by Plan Sponsor**. The County of Riverside (the "Plan Sponsor"), by formal action of its governing body or other authorized action, has formally approved the establishment of an employee benefit plan pursuant to which it or its Participating Employers will make contributions to one or more health reimbursement arrangement "HRA" plans (referred to herein individually and collectively as the "Plan") funded in a trust (the "Participating Trust") established pursuant to a trust document provided or executed in connection herewith, as the same may be amended or restated or replaced from time to time. The Plan Sponsor has also approved the use of the GBS proprietary "HealthInvest HRA" plan coverage documents governing the terms and conditions of various types of HRA plan coverage (each a "Plan Coverage Document") to implement its HRA plan and the engagement of certain service providers for the HealthInvest HRA Plan to assist the Plan Sponsor in the administration of its HRA plan.

2. **Pursuant to the governing authority of the Plan Sponsor**:

(a) HealthInvest Plan Documents. The Plan Sponsor hereby adopts the HealthInvest HRA Plan set forth in the GBS proprietary HealthInvest HRA Plan Documents (as defined in Section 1.2 of the Plan Coverage Documents), subject to the further terms and conditions contained in this Agreement and any Wrap Document, as the same may be amended, restated, or replaced from time to time as set forth therein. The Plan Sponsor agrees that it may utilize the HealthInvest HRA Plan Documents only while GBS is engaged hereunder and under the other Plan Documents as the HRA Service Manager pursuant to hereto. Upon resignation by or removal of GBS as the HRA Service Manager as provided herein and in the Plan Documents, the Plan Sponsor shall no longer have the right to utilize the proprietary GBS HealthInvest HRA Plan Documents and agrees to indemnify and hold harmless GBS and its affiliates, agents and sub-contractors, and each of their officers, employees, successors, and assigns against all costs, expenses, liabilities and damages resulting from any use of the HealthInvest HRA Plan Documents by the Plan Sponsor or any Participating Employer after the resignation by or removal of GBS as the HRA Service Manager.

(b) Plan Sponsor; Engagement of HRA Service Manager. The Plan Sponsor shall serve as the plan administrator responsible for overseeing and supervising the administration of the Plan (the "Plan Administrator" or the "Administrator") and may designate one or more representatives who may act on behalf of the Plan Sponsor in its capacity as the Plan Administrator. Without relieving the Administrator of any of its obligations under the Plan, the Plan Sponsor hereby engages Gallagher Benefit Services, Inc. ("GBS") to provide ministerial and non-discretionary Plan Administration Support Services specified in Addendum C hereto and in the other Plan Documents or otherwise at the direction of the Plan Sponsor or Administrator (in such capacity, GBS shall be referred to herein and in the Plan Documents as the "HRA Service Manager"). The Plan Sponsor authorizes and directs the HRA Service Manager to assist the Administrator in the performance and execution of all the duties, powers, and responsibilities of the

Administrator specifically defined in the Plan Documents, subject to the approval and direction of the Administrator or Plan Sponsor for any such duties, powers, or responsibilities that require the discretion of the Administrator or that are not otherwise specifically prescribed in the Plan Documents, such assistance to include without limitation the specific non-discretionary and ministerial Plan Administration Support Services described herein and in the Plan Documents. The HRA Service Manager acknowledges and agrees that the performance of the services hereunder by the HRA Service Manager and its agents and subcontractors shall be performed in a manner reasonably intended to comply with applicable law and the terms of the Plan and with a standard of care, skill, and diligence consistent with practices and procedures used in well-managed operations performing services comparable to the services to be performed by the HRA Service Manager hereunder. In addition, the HRA Service Manager will, and will cause each of its subcontractors to, obtain and maintain at its own cost all licenses and registrations required by state and federal law to operate its business and to perform the services hereunder. The Plan Sponsor acknowledges and agrees that the appointment of the HRA Service Manager to perform its services is not intended to transfer fiduciary liability to the HRA Service Manager. To the extent the Plan Sponsor delegates duties or responsibilities to the HRA Service Manager, the HRA Service Manager is not making discretionary decisions in fulfilling those duties or responsibilities. Examples of delegated duties include, but are not limited to, the publication of a summary plan description or summary of material modifications, the implementation of other forms or literature as required, or any other delegated duties and responsibilities required for plan administration purposes. The HRA Service Manager acknowledges that to the extent the HRA Service Manager exercises discretion with respect to the operation and administration of the Plan, other than ministerial and non-discretionary Administration Support Services, the HRA Service Manager may be considered a fiduciary under certain law with regard to those discretionary decisions.

(c) Role of the HRA Service Manager. The powers and responsibilities of the HRA Service Manager specified herein and in the other Plan Documents for each Participating Trust and its underlying Plans are non-discretionary and are intended for the purpose of effecting the efficient administration of this Master Trust and each Participating Trust and Plan for the benefit of and subject to the direction or approval of the Plan Sponsor, Employer, Administrator, or Employee Representative for such Plan, as specified herein or in the Plan Documents, and such powers and responsibilities are subject to the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the applicable Plan Adoption Agreement.

(d) Execution of Master Trust. The Plan Sponsor agrees to execute and direct the authorized signatory for the Participating Trust to execute the Master Trust Adoption Agreement pursuant to which the Participating Trust adopts and enters into the Master Trust, through which the Master Trustee will serve as a custodian and directed trustee on behalf of the Participating Trust and the Plan.

(e) Investment Manager. The Plan Sponsor hereby agrees to the appointment and engagement of the investment management firm identified in Addendum D (the "Investment Manager"), as a fiduciary and, if the Plan is governed by ERISA, as an ERISA 3(38) or 3(21) investment manager, as applicable, with respect to the services

expressly set forth in Addendum D or in a contract between the Plan Sponsor and the Investment Manager described in or attached to Addendum D (the "Investment Management Contract"). The authority and responsibility of Investment Manager in such capacity shall be subject to the terms and conditions set forth in the Investment Management Contract, and except as expressly provided in the Investment Management Contract and the Master Trust. Nothing in this Plan Adoption Agreement or the HealthInvest Plan Documents authorizes the Investment Manager to participate in, exercise or perform, and the Investment Manager shall not be responsible for nor participate in, exercise or perform, any duties or matters except as set forth in the Investment Management Contract. Except as specifically set forth in the Investment Management Contract, the HRA Service Manager shall have no duty to the Plan Sponsor, Participating Employers, Participants or any covered individual or beneficiary under the Plan to monitor the performance of such Investment Manager.

(f) Subcontractors of HRA Service Manager. In addition to the appointment of the Master Trustee, the Investment Manager (if applicable), and any other agents or subcontractors directly engaged by the Plan Sponsor or Plan Administrator to perform services under the Plan, the Plan Sponsor hereby authorizes the HRA Service Manager to designate one or more agents or sub-contractors to carry out any administrative services to be performed by the HRA Service Manager, including one or more HealthInvest Plan Representatives identified in Addendum C attached hereto to provide record-keeping, financial and regulatory reporting, customer service, and claims and contribution processing services. The Plan Sponsor authorizes the HRA Service Manager, and the HRA Service Manager agrees, to engage or change and otherwise deal directly with all such agents or sub-contractors, as specified in the Plan Documents, and further authorizes the HRA Service Manager to arrange for the reasonable and necessary compensation and expenses of all Plan service providers (including those engaged directly by the Plan Sponsor or the Administrator) to be paid out of the fees of the HRA Service Manager or out of Plan assets by assessment of Participant Accounts and Employer Accounts, as Plan administration expenses, all of which are either (i) identified as Administrative Fees and Expenses in Addendum C hereto or (ii) otherwise approved in writing by the Plan Sponsor to be properly payable out of Plan assets.

(g) Contributions from Plan Sponsor. The Plan Sponsor hereby agrees to contribute to a custodial account established by the Master Trustee, and directs the HRA Service Manager to cause all Plan and Trust assets to be deposited, invested, and distributed in accordance with and subject to the provisions, limitations, and requirements, of the Plan Documents. Contributions to the Plan shall be deposited with the Master Trustee directly from the Plan Sponsor by wire transfer or as otherwise directed by the Plan Sponsor in writing. Plan assets held with the Master Trustee may be registered or deposited in the name of the Master Trustee, the HRA Service Manager, or other custodian, nominee, or agent, without disclosing the name of the Plan Sponsor, the Administrator, or the Plan and, for any Accounts allocated to individual Participants and Employers for directed investing, shall be invested based upon the investment directions of such Participants and Employers.

(h) Plan Document Amendments; Amendments to Wrap Documents. It is understood and agreed by the Plan Sponsor that the GBS proprietary HealthInvest HRA Plan Documents, as amended, restated, or replaced from time to time, will be used by

multiple plan sponsors and employers who have adopted the HealthInvest HRA Plan and for which the HRA Service Manager and other service providers to the Plan provide Plan Administrative Support Services, and that unilateral amendments requested by the Plan Sponsor may not be accepted by the HRA Service Manager if the HRA Service Manager determines that it would be unable to amend all such plans or would be unable to effectively provide such services to the Plan Sponsor's plan or plans of other plan sponsors in the light of such proposed amendment. Accordingly, any Plan amendment proposed by the Plan Sponsor must be submitted to the HRA Service Manager, and such amendment shall not take effect until the HRA Service Manager delivers written acceptance of such amendment. In order for any amended or restated Wrap Document to be considered incorporated and included herein, revisions or amendments to such documents must be provided in writing thirty (30) days' in advance of implementation to the HealthInvest HRA Service Manager. The Plan Sponsor's right to unilaterally amend the Plan or any Wrap Document is subject to the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager pursuant hereto and the Plan Documents.

(i) Resignation or Removal of HRA Service Manager. The HRA Service Manager may resign and terminate this Plan Adoption Agreement at any time by giving notice in writing to the Plan Sponsor at least one hundred-eighty (180) days before such resignation is to become effective, unless such notice is waived by the Plan Sponsor. The Plan Sponsor may remove the HRA Service Manager and terminate this Plan Adoption Agreement, with or without cause, by giving notice in writing to the HRA Service Manager at least ninety (90) days before such removal is to become effective, unless such notice is waived by the HRA Service Manager. The Plan Sponsor may remove the HRA Service Manager if it objects to any amendments to the Plan Documents by giving notice in writing to the HRA Service Manager at least thirty (30) days before such removal is to become effective, unless such notice is waived by the HRA Service Manager. If the HRA Service Manager resigns or is removed for any reason, the Plan Sponsor shall transfer all Plan assets pursuant to the provisions of Plan Documents prior to the effective date of such resignation or removal, unless a longer time period for transfer is agreed upon in writing between the HRA Service Manager and the Plan Sponsor. The HRA Service Manager shall not be liable for the acts or omissions of any prior or successor Administrator or service provider providing one or more similar services to the Plan as provided by the HRA Service Manager, and, to the fullest extent permitted by applicable law, the Plan Sponsor indemnifies and holds harmless the HRA Service Manager for any losses, damages, or other liability incurred by the HRA Service Manager as a result of the actions or omissions of any prior or successor Administrator or service provider providing one or more similar services to the Plan. The Plan Sponsor's right to remove or replace the HRA Service Manager and certain other HealthInvest Plan Representatives may be subject to certain requirements set forth in the Plan Documents.

(j) Other Plan Representatives. Neither the Administrator nor the Plan Sponsor shall have the authority to remove a Plan Representative that has been engaged directly by the HRA Service Manager as a subcontractor of the HRA Service Manager to perform services or fulfill some or all of the responsibilities or obligations of HRA Service Manager under the Plan; provided, however, that if the Plan Sponsor removes a HealthInvest Plan Representative, the Plan Sponsor shall transfer all Plan assets to another administration service provider or another welfare benefit fund pursuant to the provisions of Section 8.2

of the HealthInvest HRA Plan Coverage Documents prior to the effective date of such removal, unless the transfer period requirement is waived or a longer time period for transfer is agreed upon in writing by the HRA Service Manager. Resignation, removal, and replacement of a Plan Representative that was engaged directly by the Plan Sponsor or Administrator in a separate written agreement shall be determined according to any rules, policies, procedures, or contractual arrangements between the Plan Sponsor and such Plan Representative.

(k) Wind-down; Successor Service Provider. In connection with any termination of this Plan Adoption Agreement by either party hereto, the HRA Service Manager will use best efforts to cooperate with the Plan Sponsor and any Administrator or service provider that is the successor to the HRA Service Manager to comply with reasonable requests to accomplish an orderly transition of business and, on or before the termination date, transfer of functions, books, records, documentation, data, monies and other plan assets. Prior to the termination date, the HRA Service Manager will provide all necessary staff, services, and assistance required for such orderly transfer, including participation by appropriate personnel in periodic conference calls to effect a smooth transition. For a period of seven years following any termination of this Plan Adoption Agreement, the HRA Service Manager will (i) maintain all participant-level paperwork and documentation and, upon request and at the Plan Sponsor's expense, deliver or make-available to the Plan Sponsor all or any portion of such paperwork and documentation in a manner reasonably acceptable to Plan Sponsor and (ii) cooperate and assist with any audit, examination, review, or inspection of the Plan Sponsor's HRA Plan for which the HRA Service Manager is maintaining such records.

3. **Plan Design**. Specific terms of the Plan, including the Plan Effective Date, Plan Year, revocability options, the class or classes of employees to be covered by the Plan, and the contribution policies for each class of employees, are specified in Addendums A and B hereto. The Plan Sponsor agrees that, annually, and otherwise upon the reasonable request from the HRA Service Manager, the Plan Sponsor will provide the HRA Service Manager with any Wrap Documents (subject to acceptance by the HRA Service Manager of the Wrap Document terms and conditions), census reports, current collective bargaining agreements, employment contracts, employer policies, or other information requested by the HRA Service Manager to assist the HRA Service Manager in the performance of its duties under the Plan Documents. The Plan Sponsor further agrees that the HRA Service Manager shall have the right to rely on information provided by the Plan Sponsor with respect to employee eligibility and contribution funding policies in the performance of its duties hereunder and under the Plan Documents but shall have no obligation to confirm the Plan Sponsor's or a Participating Employer's compliance with such agreements, contracts, or policies or whether such agreements, contracts, or policies comply with applicable law.

4. **Contributions**.

(a) The Plan Sponsor acknowledges and agrees that contribution(s) to the Plan will be made in accordance with obligations, policies or procedures that have been incurred or established by the Plan Sponsor or Participating Employers (pursuant to contractual agreements, collective bargaining, employer policy, or otherwise) and that neither the HRA Service Manager, nor its officers, representatives, employees, agents, or sub-contractors,

or anyone acting on behalf of or with respect to the Plan, has the right, duty or power to determine the amount to be contributed or to collect the amount to be contributed.

(b) The Plan Sponsor acknowledges and agrees that, except for premiums for COBRA continuation coverage or mandatory or other forms of employee contributions permitted by applicable law, no direct or indirect employee contributions or salary reduction contributions will be made to the Plan based upon voluntary elections by individual employees.

(c) At the time any contribution is made to the Plan, the Plan Sponsor or Participating Employer shall direct the HRA Service Manager as to the amount of such contribution to be allocated to each Participant Account and to any Employer Account. If there is a predetermined method or formula for such allocations set forth in Addendums A and B, the Plan Sponsor's or Participating Employer's allocation instruction shall be consistent therewith. However, the Plan Sponsor acknowledges and agrees that it shall be the Plan Sponsor's and/or Participating Employer's responsibility to determine the amount allocated to each Participant Account and any Employer Account, and the HRA Service Manager shall make such allocations solely in accordance with the Plan and the Plan Sponsor's or Participating Employer's specific directions and shall not be required to verify that such contribution instructions are consistent with Addendums A and B.

5. **Indemnification and Liability**. The Plan Sponsor and the HRA Service Manager (each and Indemnifying Party) agree, to the fullest extent permitted by applicable law, to indemnify and hold harmless the other (the "Indemnified Party") and its affiliates, agents and sub-contractors, and each of their officers, employees, successors, and assigns against all costs, expenses, liabilities and damages ("Losses") resulting from any negligent action or inaction, intentional misconduct, or breach of this Plan Adoption Agreement, the Plan, any Plan Document, or violation of any applicable law or rules, policies or procedures established or adopted in connection therewith on the part of the Indemnifying Party, or any of its officers, employees, agents, or Participating Employers (if applicable). Neither the HRA Service Manager, nor any agent or sub-contractor of the HRA Service Manager, nor any of their affiliates, officers, employees, successors, or assigns, shall have any liability, duty or other obligation with respect to actions or omissions of the Plan Sponsor or any of its Participating Employers (including incomplete or incorrect data provided by the Plan Sponsor or any Participating Employer or Participant) or of any custodian, trustee, investment advisor or other service provider that is not acting under the direction or control of the HRA Service Manager. Neither the Plan Sponsor, nor any agent or sub-contractor of the Plan Sponsor (not including the HRA Service Manager), nor any of their affiliates, officers, employees, successors, or assigns, shall have any liability, duty or other obligation with respect to actions or omissions of the HRA Service manager or any of its subcontractors (including incomplete or incorrect data provided by the HRA Service Manager or any of its subcontractors) or of any custodian, trustee, investment advisor or other service provider that is not acting under the direction or control of the Plan Sponsor. To the extent the HRA Service Manager or any other Plan Representative incurs any costs, expenses, liabilities or damages in connection with the timeliness or correctness of amounts contributed to the Plan or transferred to the Plan from another welfare benefit plan, then the Plan Sponsor and Employer (but only to the extent either is responsible for the same) agree to indemnify and hold harmless the HRA Service Manager, and other Plan Representatives with respect to such costs, expenses, liabilities or damages. Notwithstanding anything in this Plan Adoption Agreement to the contrary, neither

Indemnifying Party shall be liable for any punitive, consequential, special, or indirect Losses, whether or not the likelihood of such Losses was known by that party.

6. **No Guarantees**. The Plan Sponsor acknowledges and agrees that there may be loss or depreciation of the value of any investment due to the fluctuation of market values and that neither the HRA Service Manager, Investment Manager, nor any other service provider to the Plan guarantees the Plan or any Participant Account or Employer Account thereof from loss or decline in value, or the payment of any amount that may become due to any person thereunder. Nothing contained in the Plan or any trust document shall constitute a guarantee by the HRA Service Manager, Investment Manager, or any other person that the assets of the Plan will be sufficient to pay any benefit to any person or make any other payment; payments to be paid to Participants or the Plan Sponsor or a Participating Employer from the Plan are limited to the assets remaining in the applicable Participant Account or Employer Account at the time payment is made and such other limits as may apply based upon the Plan Sponsor's plan design and applicable law.

7. **Compensation and Expenses**. The Plan Sponsor accepts and agrees to the schedule of fees and expenses set forth in Addendum C and acknowledges and agrees that, to the extent permitted by law, and except as otherwise specified in Addendum C, such fees and expenses will be paid out of Plan assets, to be allocated to Participant Accounts and Employer Accounts in the manner described in Addendum C or as otherwise determined by the Plan Sponsor. The HRA Service Manager shall provide the Plan Sponsor advance written notice of any increase or decrease in fees or expenses of the Plan, including any increases or decreases attributable to changes in elections under this Agreement, and the Plan Sponsor agrees that it shall be deemed to have approved any such change in fees or expenses, subject to the Plan Sponsor's right to remove the HRA Service Manager and the HRA Service Manager's right to resign as provided herein and in the Plan document.

8. **Plan Sponsor Amendments to Plan Elections**. The Plan Sponsor may amend its elections under this Plan Adoption Agreement at any time, provided, however, that (1) no such amendment may be inconsistent with the terms of the Plan, (2) any such amendment shall be subject to acceptance by the HRA Service Manager (including confirmation that the HRA Service Manager can continue to provide Plan Administration Support Services on behalf of the Plan Sponsor and participating plan sponsors) and the Plan Sponsor's acceptance of any additional fees or charges that may result from such changes by the Plan Sponsor in its Plan elections, (3) to the extent that contributions have been made on behalf of any Participant and have vested prior to the effective date of the amendment, such amendment may not increase the term of any vesting schedule with respect to such contributions, unless participant or his or her bargaining representative agree to the increase and (4) with respect to Plan contributions made before the effective date of the amendment, such amendment may not modify the revocability elections of Addendum A hereto to allow additional amounts to be returned to the Plan Sponsor.

9. **Governing Documents**. The Plan Sponsor hereby adopts and establishes such rules, policies and procedures as are set forth in the Plan Documents or Plan forms and materials, as the same may be amended from time to time. To the extent not set forth therein, and subject to the Plan Sponsor's right to remove the HRA Service Manager herein and in the Plan Documents, the HRA Service Manager is hereby authorized and directed to establish such rules, policies, practices and procedures, and amendments to the Plan Documents as it deems appropriate for the administration of the Plan, all of which shall govern the Plan and be binding upon the Plan Sponsor,

Plan Administrator, Participating Employers, Participants, and other individuals who may be entitled to Benefits from a Participant Account.

10. Construction of Documents. The Plan, the Plan Adoption Agreement, along with any applicable Wrap Documents and each Enrollment File are all parts of a single, integrated employee benefit system and shall be construed together. Where necessary or appropriate to the meaning thereof, the singular shall be deemed to include the plural, the plural to include the singular, the masculine to include the feminine, the feminine to include the masculine. Any written document referenced herein, including any Plan Document, shall mean such document as amended and restated from time to time.

11. Terms Incorporated by Reference; Conflicting Provisions. Capitalized terms used herein and not defined herein shall have the meanings ascribed to such terms in the other applicable Plan Documents. In the event there is a conflict among the terms of two or more documents or in the definition ascribed to any term in two or more documents, interpretation shall be determined by reference first to the Plan Sponsor Contract (defined below), if any, then to any Wrap Documents, then to the Master Trust, then to the Master Trust Adoption Agreement, then the applicable HRA Plan Document, then to the Summary Plan Description, then to this Plan Adoption Agreement, then to the applicable Enrollment File, and then to the Participating Trust Document.

12. Prior or Contemporaneous Agreements.

(a) Except as provided in subsection (b) of this Section, this Plan Adoption Agreement supersedes all prior or contemporaneous agreements or understandings between the Plan Sponsor and GBS, whether oral or written, regarding the matters pertaining hereto that are not specifically referenced and made a part of this Plan Adoption Agreement. This Plan Adoption Agreement may be amended only in writing, and no purported oral agreement or understanding, or conduct or course of conduct, will be binding on any party hereto, unless reduced to writing and executed by authorized officers of all parties hereto.

(b) If the Plan Sponsor and GBS have entered into a separate written agreement governing the terms and conditions of GBS's services as the HRA Service Manager for the Plan Sponsor, such agreement shall be referred to herein as the "Plan Sponsor Contract" and attached hereto as Addendum F. In the event of a conflict between this Plan Adoption Agreement and the Plan Sponsor Contract, the terms of the Plan Sponsor Contract, shall at the election of either the Plan Sponsor or GBS, control.

13. Notices. Any notice required or permitted under this Agreement or the Plan Documents shall be in writing and shall be deemed delivered when deposited in the United States mail, postage prepaid, certified mail, return receipt requested, addressed to the respective parties at the addresses set forth below and in Addendum C with respect to the Investment Manager and in the other Plan Documents for any other Plan Representative engaged directly by the Plan Sponsor.

(a) The address for delivery of all communications to the Plan Sponsor are set forth on the Plan Sponsor Data Sheet attached to this Plan Adoption Agreement.

(b) The address for delivery of all communications to the HRA Service Manager shall be:

ATTN: HRA Service Manager
Gallagher Benefit Services, Inc.
906 West 2nd Avenue Suite 400
Spokane, WA 99201-4537
(509) 838-5571

14. HIPAA Requirements and Certification; Applicability of State Laws; and Applicability of Nondiscrimination Rules.

(a) Plan Sponsor acknowledges that the Plan is a "Covered Entity" and meets the definition of a "Health Plan," as such terms are defined under the Health Insurance Portability and Accountability Act of 1996, as the same may be amended from time to time ("HIPAA") and the regulations thereunder, as the same may be amended from time to time ("HIPAA Regulations"). The Plan Sponsor agrees to execute the HIPAA Business Associate Agreement attached hereto as Addendum E and to execute any amendments thereto or replacements thereof as required by law. Plan Sponsor and its Participating Employers may be required to adopt certain policies and procedures on behalf of the Plans that are prescribed by HIPAA and the HIPAA Regulations. Plan Sponsor accepts responsibility for compliance with HIPAA and the HIPAA Regulations for itself and on behalf of any Participating Employers. The Plan Sponsor hereby acknowledges that the Plan incorporates the provisions of 45 C.F.R. § 164.504(f)(2)(ii), and the Plan Sponsor hereby agrees to the conditions of disclosure described therein.

(b) Plan Sponsor acknowledges that various state laws applicable to the Plan Sponsor or Participating Employers may affect certain aspects of the Plan or the Plan Sponsor's ability to adopt the Plan. These may include, without limitation, state laws regarding the investment of public funds, the permissibility of the Plan Sponsor to act as a trustee or fiduciary, conflicts with other statutory or state-sponsored plans, state agency reporting requirements, and the applicability of state income taxes. Plan Sponsor should seek the advice of its own legal or tax counsel for such state-law issues.

(c) Plan Sponsor acknowledges that IRC § 105(h) prescribes nondiscrimination rules with respect to eligibility and the contributions to and benefits of the Plan. Plan Sponsor acknowledges that neither the HRA Service Manager, nor any of its affiliates, sub-contractors, agents, representatives, officers, or employees accepts any responsibility for Plan Sponsor's compliance with IRC § 105(h) and that the Plan Sponsor will review its own collective bargaining agreements, and eligibility and contribution policies with its own legal and tax counsel to confirm compliance with these legal requirements.

15. Counterparts. This Plan Adoption Agreement may be executed in one or more counterparts, each of which shall constitute an original, and all of which together will constitute one and the same agreement. Facsimile delivery transmission or electronic delivery in portable

document formation (".pdf") or tagged image formation (".tiff") by any party hereto of its executed counterpart shall constitute the valid and binding execution hereof by such party.

16. **Assignability**. This Agreement calls for the personal services of the HRA Service Manager and for certain financial and other specified obligations of Plan Sponsor. The HRA Service Provider shall not assign its rights or obligations hereunder, without the prior written consent of the Plan Sponsor. The Plan Sponsor shall not assign its rights or obligations hereunder, without the prior written consent of the HRA Service Provider. Notwithstanding the foregoing, the HRA Service Provider shall have the right to assign this Agreement to any successor to all or substantially all of its assets and business by dissolution, merger, consolidation, transfer of assets or otherwise, or to any entity owned or controlled by Arthur J. Gallagher & Co., without the prior consent of the Plan Sponsor.

17. **Successors and Assigns**. This Plan Adoption Agreement shall be binding upon and shall inure to the benefit of the parties hereto and each of their respective successors and assigns to the extent permitted hereby.

18. **Governing Law; Jurisdiction**. This Plan Adoption Agreement shall in all respects be interpreted, enforced and governed in and under the laws of the state of domicile of the Plan Sponsor, without reference to choice of law principles. Should any provision of this Plan Adoption Agreement be declared or determined by any court to be illegal or invalid, the validity of the remaining parts shall not be affected thereby and the illegal or invalid part shall be deemed not to be a part of this Plan Adoption Agreement. Any dispute arising under or in connection with this Plan adoption Agreement shall be subject to the exclusive jurisdiction of the state or federal courts located in Washington.

19. **[Reserved]**

IN WITNESS WHEREOF, the Plan Sponsor hereby executes and delivers this Plan Adoption Agreement, as evidenced by the signature below of authorized officer thereof and upon written acceptance by the HRA Service Manager below, shall be effective as of the Plan Effective Date.

Each party certifies that the individual signing below has the authority to execute this Agreement on behalf of such party and may legally bind such party to the terms and conditions of the Agreement, including any attachments hereto.

ATTEST:

Clerk of the Board
Kecia R. Harper

By: _____
Deputy

Date: FEB 11 2020

COUNTY OF RIVERSIDE:

By: _____
V. Manuel Perez
Chairman, Board of Supervisors

Date: FEB 11 2020

Approved as to Form:
Gregory P. Priamos
County Counsel

By: _____
Chief Deputy County Counsel
SYNTHIA M. GUNZEL

Accepted by the HRA Service Manager

Gallagher Benefit Services, Inc.
As the HRA Service Manager

By: _____
Authorized Signatory

Printed Name: Charlie Isaacs

Title: Area President

Dated: 1-21-20

Gallagher | HealthInvest HRA

ADDENDUM A

Plan Design Elections and Administration

HealthInvest HRA

PLAN DESIGN ELECTIONS

Plan Sponsor agrees to deliver to the HRA Service Manager written amendments to this Addendum A from time to time as employee groups to be covered by the Plan and eligibility requirements change.

General Plan Options

1. **Effective Date**. The Plan Effective Date for the Plan shall be January 1, 2012.

2. **Plan Year**. For regulatory reporting and compliance under federal law, the HealthInvest HRA Plan Year is based upon the calendar year. Depending on the date of adoption, the first Plan Year for certain Plans may be less than 12 months.

3. **Transfers**. *(check one only)*

   (a) ☐ No transfer of assets from another plan is contemplated.

   (b) × The following transfer of assets from one or more other plans is contemplated (*describe**):

   Transfer of assets from existing third-party administrator, Rehn & Associates.

   Transfers of assets from other plans shall be on terms acceptable to, and pursuant to rules, policies and procedures established by, the HRA Service Manager.

4. **Wrap Documents**. *(check one only)*

   (a) × The Plan Sponsor ***does not elect*** to have Wrap Documents incorporated into this Plan Adoption Agreement.

   (b) ☐ The Plan Sponsor ***elects*** to have the Wrap Documents attached to this Addendum A and incorporated into this Plan Adoption Agreement,

5. **Employer Account(s)**. *(check one only)*
   An Employer Account can be used to hold assets to be applied to future obligations or contributions of the employer and/or to offset other post-employment benefits (OPEB) liabilities resulting from Governmental Accounting Standards Board Statement No. 74/75 (GASB 74/75) accounting rules. An Employer Account, if established, can also be used for

the purpose of accepting Participant Account forfeitures due to a Participant's death, failure to meet vesting requirements, if any, and other terms and conditions of the Plan.

☐ Plan Sponsor is establishing one or more Employer Accounts for itself or establishing one or more Employer Accounts as elected by each Participating Employer.

× Plan Sponsor is not establishing any Employer Account.

6. **Limited Reversion and Revocability Elections**.[1] No Plan assets (other than contributions made by mistake of fact or administrative error) shall be returned to the Plan Sponsor except upon satisfaction of all liabilities to provide benefits under the Plan and in the following additional circumstances. *(check one only or check "None of the Above")*

☐ Plan assets allocated to any Employer Account may be returned to the Plan Sponsor or Participating Employer, as applicable, at any time, to the extent permitted by the applicable Participating Trust. (If this option is selected, Plan assets may not be counted as employer assets for meeting the requirements of GASB 74/75.)

☐ All Plan assets, or the portion thereof allocable to a designated class of Participants, may be returned to the Plan Sponsor for the purpose of providing health benefits to Participants, or such class of Participants, under a successor health plan, to the extent permitted by the applicable Participating Trust.

☐ All forfeited Plan assets, or the portion thereof allocable to a designated class of Participants, may be returned to the Plan Sponsor at any time to the extent permitted by the applicable Participating Trust.

☐ Other (specify). _____

× None of the Above.

The Plan Sponsor certifies that the reversion and revocability elections above are permitted by the Participating Trust and the Plan Sponsor assumes, and holds the Master Trustee and HRA Service Manager harmless from, all liability, including adverse tax consequences associated with such elections.

7. **Participant Account Types**. The Plan Sponsor shall designate the description, eligibility, benefits, and other approved terms and conditions for one or more Participant Account types to be established for each employee group of Participating Employer as described in Addendum B.

8. **Please specify** below any other specific instructions or Plan limitations. *(Subject to acceptance of such terms by the HRA Service Manager)*

[1] Reversion elections are not permitted for plan assets funded through a VEBA trust and may not be permitted by the terms of other types of trust instruments. Plan Sponsors should consult with legal counsel.

N/A

Gallagher | HealthInvest HRA

ADDENDUM B

Participant Account Elections

In this Addendum, follow the instructions to make elections for each Participant Account Type.

HealthInvest HRA

INSTRUCTIONS FOR PARTICIPANT ACCOUNT ELECTIONS

This Addendum B allows a Plan Sponsor to:

- Establish one or more Participant Account types
- Indicate which eligible Employee group(s) will be receiving contributions to one or more Participant Account types
- Provide a brief description for each Participant Account type as you would want it to appear on Participant Communication. Descriptions are usually based on either the type of contribution, type of coverage, or eligible employee group. For example: Monthly Contributions (In-service Benefits); Annual Contributions (Post-separation Benefits Subject to Vesting); Separation Pay; Executive Premium-only Coverage; Administrators; Professional Staff; Support Staff; etc.
- Choose the benefits for each Participant Account type

The number of Participant Account types a Plan Sponsor establishes may be dependent upon its chosen or negotiated Plan design, compliance with certain Affordable Care Act (ACA) rules, or compliance with applicable nondiscrimination rules when making contributions on behalf of highly compensated individuals (HCIs), etc.

Participant Account Types.

The In-service HRA Plan pays benefits (subject to vesting requirements) while the employee is actively employed and continuing after retirement or other separation from service from the Employer. The Post-separation HRA Plan pays benefits only after eligible Employees meet all vesting requirements and also retire or otherwise separate from service from the Employer. The Post-separation, premium-only plan design is generally used to provide additional benefits to highly compensated employees and pays benefits only for qualified premiums incurred after eligible Employees meet all vesting requirements and also retire or otherwise separate from service from the Employer.

Multiple Account Options. It is possible that one or more eligible Employee groups (or certain eligible Employees within the same Employee group) may receive contributions to more than one Participant Account type. For example, you may make a $100 per month contribution into the In-service HRA Plan for all eligible employees and an additional $75 dollars per month for HCIs into the Post-separation HRA Plan that is limited to executive premium-only benefits and subject to vesting.

On the Enrollment File for each eligible group, the Plan Sponsor or Participating Employer must specify the one or more Participant Account types into which the Participants are enrolling. The Plan Sponsor must also submit separate or combined contribution remittance reports for each Participant Account type into which contributions are being made based upon the number (division code) assigned to each Participant Account type by the HRA Service Manager (*e.g.*, "001", "002" or "003", *etc.*).

Default Post-separation Contributions. For contributions to the In-service HRA Plan for a particular Employee group, some Employees may not meet the ACA integration requirements that require the Employee to be covered by a group health plan at the time the contribution is credited. This will result in some eligible Employees within the same group receiving contributions into the In-service HRA Plan and other eligible Employees receiving contributions into the Post-separation HRA Plan, which is not subject to the ACA integration requirements.

> ***Example***: The Plan Sponsor or Participating Employer intends to make a contribution of $100 per month into the In-service HRA Plans with 100% vesting. From time to time, if any Employees within that group do not meet the ACA integration requirements under any of the In-service HRA Plans, applicable law requires that the $100 monthly contribution for these Employees must be directed into a separate Participant Account type with 100% vesting under the Post-separation HRA Plan. ***These contributions are referred to as "Default Post-separation Contributions."*** This Default Post-separation Participant Account type will be automatically established by the HRA Service Manager to accommodate Default Post-separation Contributions on behalf of any Employees who do not meet the ACA integration requirements from time to time.

HealthInvest HRA

PARTICIPANT ACCOUNT ELECTIONS

If establishing more than six Participant Account Types, please complete and attach additional copies of this form.

1. Establishment of Participant Account Type(s). [Participant Account type number (division code) will be assigned by the HRA Service Manager and communicated to the Plan Sponsor or Participating Employer]

   Participant Account Type Description: Insert a brief description of your choosing, as you would want it to appear on Participant Communication.

   Eligible Employee Group(s): List each Employee group eligible for contributions to the respective Participant Account Type.

   Benefits: Check only one Benefits option for each Participant Account Type. *Do not elect "Post-separation HRA Plan coverage" below if the only contributions to the Post-separation HRA Plan will be "Default Post-separation Contributions" (defined in Item 6 of Addendum A-1 Plan Design Elections). If you choose any of the "In-service HRA Plan coverage" options below, a separate, corresponding "Post-separation HRA plan coverage" Participant Account type for "Default Post-separation Contributions" (defined in Item 6 above) will be automatically set up on behalf of eligible employees, if any, who do not meet the integration requirements under any of the In-service HRA Plan versions.*

		Benefits (type of coverage)					
		Post-separation HRA Plan Coverage				In-service HRA Plan Coverage	
Participant Account Type Description	Eligible Employee Group(s)	100% Vested	Subject to Vesting	Premium-only 100% Vested	Premium-only Subject to Vesting	100% Vested	Subject to Vesting
Post-separation		×	☐	☐	☐	☐	☐

2. Claims Eligibility Date. The Claims Eligibility Date for Participant Account Types with Post-separation HRA Plan Coverage shall be the Participant's date of retirement or separation from employment. The Claims Eligibility Date for Participant Account Types with In-service HRA Plan Coverage shall be the Participant Eligibility Date or, if subject to vesting, the date after the Participant Eligibility Date on which the applicable vesting requirements have been met by the Participant.

3. Vesting. [Describe below, or in an attachment to this Addendum B-2, the vesting policy for each eligible employee group subject to vesting, if any.]

N/A

(Please note that Plan Sponsors and Participating Employers are responsible for tracking Employee vesting and notifying the HRA Service Manager or its designee of vested amounts when Employees separate or as applicable.)

4. Forfeitures. If the balance in any Participant Account is forfeited in accordance with the terms of the Plan, such account balance will be transferred, reallocated, or re-contributed in accordance with written directions of the Plan Sponsor or Participating Employer, as applicable.

ADDENDUM C

Administrative Fees Schedule, Plan Administration Support Services, and Plan Representatives

ADMINISTRATIVE FEES SCHEDULE

HealthInvest HRA Plan

ADMINISTRATIVE FEE SCHEDULE

The following schedule of administrative fees will apply. Administrative fees include expenses for routine operation, administration, and regulatory compliance for the Plan.

1. **Monthly Per Participant Account Fee:** **$1.25 claims-eligible**

   This amount will be deducted once per calendar month from Participant Accounts unless Employer elects below to pay this fee.

   ☐ Check here if Employer will pay. Monthly account fees will be invoiced to Employer monthly. Invoiced amounts shall be due and payable by Employer within 30 days.

2. **Annualized Participant Account Fee:** **0.20%**

   This fee will be prorated and deducted from Participant Accounts on a daily basis at a rate of 1/365 of the listed annualized fee unless Employer elects below to pay this fee.

   ☐ Check here if Employer will pay. Annualized participant fees will be calculated and invoiced to Employer monthly. Invoiced amounts shall be due and payable by Employer within 30 days.

3. **Employer Set-up Fee:** **N/A**

   Employer will be invoiced at time of Plan adoption. Invoiced amounts shall be due and payable by Employer within 30 days.

4. **Employer Annual Fee:** **N/A**

   Employer will be invoiced beginning in year two and each year thereafter. Invoiced amounts shall be due and payable by Employer within 30 days.

5. **Trust-level Expenses:** **As incurred**

   Employer will be invoiced beginning in year two and each year thereafter. Invoiced amounts shall be due and payable by Employer within 30 days.

   Expenses related to the overall operation of the Plan Sponsor Trust on behalf of all participating employers, including, but not limited to, annual audit, completion and filing of IRS Form 990 return, legal fees, fiduciary liability insurance or fidelity bond(s) purchased as permitted by the Plan Documents, and other expenses incurred as part of the administration of the Trust, and split in accordance with the Plan Documents.

☐ Check here if Employer will pay.

☐ Check here if Trust-level Expenses should be split equally among Employer's Participant Accounts.

6. **Termination/Transfer Fee:** N/A

Employer will be invoiced at the time of termination/transfer. Invoiced amounts shall be due and payable by Employer within 30 days.

7. **Annual Patient-Centered Outcomes Research Institute (PCORI) Fee**:

The PCORI Fee is an annual per-participant fee assessed by the federal government as required under federal healthcare reform regulations. The PCORI fee increases each year (through Plan Years beginning in 2019) based on increase in the projected per capita amount of national health expenditures.

For non-ERISA Plans that are subject to this fee, the account of any Participant who is eligible to file claims will be charged a prorated portion of this annual fee once every three months during the Plan Year beginning in 2017 through the Plan Year beginning in 2019, or as otherwise mandated by federal law.

For ERISA-governed plans that are subject to this fee, the fee will be calculated by the HRA Service Manager and payable by the Plan Sponsor. The fee applies to claims-eligible participants only and does not include their spouses and dependents. The amounts collected will be remitted to the federal government to fund patient-centered outcomes research.

This Administrative Fee Schedule does not include investment fund operating expenses. Fund operating expenses vary by fund and are expressed in Plan literature as an annualized percentage of assets. Fund operating expenses are applied at the fund level.

Additional Fee Information:

PLAN ADMINISTRATION SUPPORT SERVICES

Plan Administration Support Services that may be provided by the HRA Service Manager or any subcontractor of the HRA Service Manager shall include non-discretionary assistance and support for the Administrator in the performance of all duties, powers, and responsibilities of the Administrator specifically set forth in the Plan Documents, policies, or procedures, and other Plan forms and materials (as the same may be amended from time to time) and other non-discretionary duties powers, and responsibilities approved or directed by the Plan Sponsor from time to time, including without limitation the following administration support services:

1. Provide assistance to Plan Sponsor and Participating Employers with Plan design elections and completion of plan adoption documents.
2. Provide Plan Sponsor and Participating Employers with Plan adoption/welcome package after receipt of a completed adoption agreement in good order.
3. Design and print Plan literature (including, but not limited to, enrollment forms, claim forms, Investment allocation forms, question-and-answer forms, Plan Summary/Summary Plan Description, etc.).
4. Maintain an inventory of necessary forms and literature
5. Draft, create, and make any changes to Plan documents, Plan forms, Plan materials, Plan literature, and Plan policies and procedures as are routine, desirable, or necessary to improve the efficiency and effectiveness of the operation of the Plan, clarify ambiguities for the benefit of the Administrator, Plan Sponsor, or Eligible Participants, and to comply with applicable legal requirements.
6. Assist with communication between, and coordinate the activities of, all subcontractors and service providers to the Plan.
7. Facilitate payment of operating expenses of the Plan in accordance with the Plan Documents and direction of the Administrator.
8. Provide reasonable assistance and services necessary to obtain or make all necessary regulatory or other governmental filings, registrations and approvals for this Plan, including providing information and reports to the Plan Sponsor and Participating Employers
9. Maintain and provide access to all records of the custodian, the HRA Service Manager and others relative to the Plan as needed for Plan and Trust audits.
10. Provide recordkeeping services for Participant and Employer Accounts.
11. Provide ministerial claims reimbursement services to Participants and Employers (for Employer Accounts). Claims reimbursement services include determination if a receipt is valid and covers a qualified expense under IRC § 213(d), and delivery of all applicable notices required in the Plan document. Any determination on appeal requiring discretion must be approved in writing by the Administrator. Claims reimbursement services may include a healthcare debit card for participants to use for certain permitted expenses, as negotiated and subject to terms and conditions of the card vendor.

12. Provide customer care center (call center) service and assistance to Participants relating to enrollment, Plan benefits, account changes, investment allocations, website and other Plan questions and assistance.

13. Provide technical, compliance, and educational support to the Plan Sponsor, Participating Employers, and Eligible Participants.

14. Draft periodic Plan Sponsor/Participating Employer and Participant communications regarding legal and compliance updates, participant rights and responsibilities, and reminders regarding Plan benefits, policies, and procedures, etc.

15. Prepare and deliver notices and documents to Participants and Plan Sponsor/Participating Employer, as necessary, desirable, or required by law.

16. Recommend and implement operational and compliance policies and procedures for the effective and efficient and compliant operation of the Plan.

17. Provide custodian and transfer agent services with respect to all Plan assets.

18. Assist with the investigation of errors reported to the Plan by a Plan Sponsor, Employer, or Participant.

PLAN REPRESENTATIVES

- **Gallagher Benefits Services, Inc. ("GBS")**, in its capacity as the HRA Service Manager and subcontractor of GBS.
- **Gallagher Fiduciary Advisors, Inc. ("GFA")**, in its capacity as the investment manager, but if the Plan Sponsor elects the HealthInvest HRA standard fund lineup and in such case only with to the extent of the scope of services described in Addendum D hereto.
- **Washington Trust Bank**, in its capacity as Custodian and Master Trustee.

Any other Plan Representative that is required for the uniform management and administration of the HealthInvest HRA Plan and which is identified in the Plan Adoption Agreement or otherwise designated in writing by the HRA Service Manager as a HealthInvest Plan Representative.

ADDENDUM D

Investment Management Services

Following this page is a copy or description of the Investment Management Contract between the Plan Sponsor and the Investment Manager appointed by the Plan Sponsor as provided under Section 2(e) of the Plan Adoption Agreement.

For any Plan Sponsor who elects a custom fund lineup or engages its own investment manager for its HealthInvest HRA Plan, the following pages in this Addendum D will be removed and replaced with a copy or description of the Investment Management Contract between the Plan Sponsor and the Investment Manager appointed by the Plan Sponsor as provided under Section 2(e) of the Plan Adoption Agreement.

HealthInvest HRA

INVESTMENT MANAGEMENT
SCOPE OF SERVICES

Pursuant to the Plan Adoption Agreement, the Plan Sponsor has agreed to the appointment and engagement of Gallagher Fiduciary Advisors, LLC ("GFA"), a wholly-owned subsidiary of GBS to perform the services specifically described in this Addendum D and subject to the terms and conditions set forth in this Addendum D and elsewhere in this Plan Adoption Agreement. As a fiduciary and investment manager, GFA shall provide the following services regarding the Assets, other than Assets consisting of stable value funds and annuity contracts, to the HealthInvest HRA Service Manager:

(a) Develop a Statement of Investment Objectives (the "Statement") or review and revise, as appropriate, the existing Statement.

(b) Report to the HRA Service Manager on a quarterly basis the performance of each Investment Manager in the HealthInvest HRA fund lineup. This includes providing a quarterly evaluation report in writing. In addition, GFA will attend one meeting by telephone per year with the HRA Service Manager. Each report shall set forth separately the performance of each Investment Manager, including an evaluation of the returns achieved against suitable benchmarks for performance and risk. GFA hereby gives the HRA Service Manager permission and authority to deliver a current copy of such written reports to the Plan Sponsor either in hard copy or electronic form and to make a copy of the same available to the Plan Sponsor on the HealthInvest HRA Plan website or employer portal.

(c) Evaluate and report to the HealthInvest HRA Manager on the investment impact of plan amendments that may be considered, subject to receipt of reasonable advance notice of proposed amendments and sufficient additional input from the Trustees and appropriate Service Providers.

(d) Evaluate and decide which, if any, of the Investment Managers is appropriate to manage which, if any, portion of the Assets, consistent with the Statement and with the investment guidelines.

(e) Identify, evaluate and select additional Investment Managers (including, as appropriate, one or more "transition managers" to effectuate the transfer of Assets among Investment Managers in the event of the termination or addition of a Manager or a reallocation of the assets) and/or Pooled Investment Funds consistent with the Statement including but not limited to selection of investment funds to which the Plan's participants may direct their accounts. Identification, evaluation and selection will include Pooled Investment Funds the underlying assets of which are considered to be Assets of the Plan under ERISA (if the Plan is governed by ERISA), for which GFA will have the sole responsibility as 3(38) investment fiduciary to evaluate, select and appoint the individual or entity responsible for management of each such Pooled Investment Fund.

(f) Prudently monitor all Investment Managers and all Pooled Investment Funds and decide whether and when to terminate any Investment Manager and whether and when to withdraw from any Pooled Investment Fund.

(g) Exercise rights (including, without limitation, voting rights and redemption rights) of the Master Trust as a limited partner, member, shareholder, unitholder, participant or similar capacity in the commingled investment vehicles in which the Master Trust invests and such other Pooled Investment Funds in which GFA may determine to invest the Assets in pursuant to (g) above.

(h) Negotiate and execute on behalf of Master Trust or direct the Master Trustee or Administrator to execute such investment management agreements and other agreements and instruments which GFA determines are appropriate to carry out its determinations with respect to the Assets of the Plan. GFA shall have the right to engage legal counsel as needed to review and comment on such agreements at its own cost.

As a fiduciary and investment advisor, GFA shall provide the following services regarding stable value funds and group annuity contracts (the "3(21) Assets") to the HRA Service Manager and Plan Sponsors:

a) Assist in the evaluation and maintenance of an appropriate line up for the Plan of 3(21) Assets, recommending both the number and type of 3(21) Assets available for the Plan Sponsor's Plan.

b) Evaluating and recommending which, if any, of the Plan's current Investment Managers is appropriate to manage any 3(21) Assets, consistent with the investment policy statement of the Plan and recommending replacement of any Manager where appropriate.

c) Identifying, evaluating and recommending selection of additional or different Investment Managers, when and to the extent directed by the Plan Sponsor, after consultation with the Plan Sponsor and consistent with the Plan's investment policy statement.

d) Monitoring and advising the Plan and Plan Sponsor regarding the reasonableness of fee arrangements between and among the Plan and Investment Managers for the Plan's 3(21) Assets, provided that such advice shall not involve rendering legal advice, and the Plan's legal counsel shall be responsible for drafting all service provider agreements.

e) On a monthly basis, evaluate the performance of the Plan's Investment Managers of the Plan's 3(21) Assets and prepare performance analytics for multiple periods (e.g. MTD, QTD, YTD, etc.) and submit report to the Plan electronically.

f) Measure and evaluate on a quarterly basis the performance of each Investment Manager of the Plan's 3(21) Assets. Compare investment results with appropriate indices and/or benchmarks and peer groups, providing appropriate analysis and advice. Meet with the Plan Sponsor to review quarterly performance evaluation report. In person meetings with the Plan's Investment Committee are limited to one per year, whereas telephonic meetings shall be as reasonably as requested by the Plan.

g) Providing assistance reasonably required by the Plan to respond to audits or examinations conducted by governmental agencies relating to the investment of the 3(21) Assets.

h) Reviewing as appropriate each 3(21) Assets Investment Manager's adherence to the applicable written investment guidelines and objectives and recommending to the Plan Investment Committee and Manager corrective action as needed.

Gallagher

HealthInvest HRA

March 31, 2019

Investment Fund Overview

You can invest your **HealthInvest HRA** by choosing from a menu of available fund options. This lets you pick your investments based on what is most important to you.

- Your tolerance for risk and potential fluctuations in your account value
- The length of time until you expect to begin using your HRA (in-service versus post-separation HRA coverage)
- Whether you want to **grow** your account or **preserve** your account
- Investment management style, fund objectives, and fees
- Diversification

This **Investment Fund Overview** for your Plan is updated quarterly and contains historical performance data for each available fund. To get a current copy, log in at **healthinvesthra.com** and click **Resources**. Remember, past performance does not guarantee future results.

You should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Visit the sites listed below for information about investing.

- **https://investor.vanguard.com/investing/how-to-invest/**
- **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/pension-protection-act/investing-and-diversification**

Making a Change

To review or change your current investment selection, log in at **healthinvesthra.com** and click **Investments** on the menu bar.

- Your HRA will remain invested in your plan's default investment fund until you make a change.
- You can use any combination of available funds.
- You can make changes up to once per calendar month.
- If you are in multiple funds, medical care expense reimbursements from your HRA will be prorated based on your balance in each fund.

Investing involves risk, and you could lose money. You should consult with a professional financial advisor before making investment decisions. This Investment Fund Overview does not contain investment advice. HealthInvest HRA representatives do not give investment advice.

Expenses & Fees

Investment fund operating expenses vary by fund as shown in this **Investment Fund Overview**. Plan administrative fee structures vary by plan sponsor and usually include a flat monthly account fee and/or an annualized asset-based fee. These fees are deducted from your account or paid by your employer or plan sponsor. Fees deducted from your account are listed on your account statements under **Important Notes**.

Fees are used to pay plan expenses, such as enrollment and claims processing, plan management, recordkeeping, legal, compliance, printing, banking and custodial, web management, investment management, postage, etc. To the extent permitted or required by law, certain fees, assessments, or other amounts payable to the federal government may also be deducted from your account. It is possible that fees could exceed your investment return.

Fund Name (Ticker) Objective	Asset Category	Risk Level	Fund Operating Expense (%)	Average Annual Returns (%)* YTD 2019	Calendar Year 2018	Calendar Year 2017	Calendar Year 2016	1-Year as of 3/31/19	3-Year as of 3/31/19	5-Year as of 3/31/19	10-Year as of 3/31/19
TARGET ALLOCATION											
BlackRock 20/80 Target Allocation Fund K (BKCPX) Seeks a balance between long-term capital appreciation and high current income, with an emphasis on income. Normal exposure: 20% equity securities; 80% fixed-income securities. www.blackrock.com	Conservative Allocation	Low	0.42	5.21	-2.20	8.06	3.09	3.89	4.31	4.04	8.55
BlackRock 40/60 Target Allocation Fund K (BKMPX) Seeks a balance between long-term capital appreciation and high current income, with an emphasis on income. Normal exposure: 40% equity securities; 60% fixed-income securities. www.blackrock.com	Moderately-Conservative Allocation	Low Moderate	0.43	7.04	-3.70	11.68	4.42	3.96	6.14	5.01	10.05
BlackRock 60/40 Target Allocation Fund K (BKGPX) Seeks long term capital appreciation, and current income is also a consideration. Normal exposure: 60% equity securities; 40% fixed-income securities. www.blackrock.com	Moderate Allocation	Moderate	0.38	9.17	-5.86	14.80	5.11	3.47	7.51	5.38	10.88
BlackRock 80/20 Target Allocation Fund K (BKAPX) Seeks long term capital appreciation. Normal exposure: 80% equity securities; 20% fixed-income securities. www.blackrock.com	Moderately-Aggressive Allocation	Moderate High	0.30	11.16	-7.64	17.49	6.86	3.16	9.08	6.19	12.34
MONEY MARKET											
Vanguard Federal Money Market Investor (VMFXX) Seeks to provide current income while maintaining liquidity and a stable share price of $1. www.vanguard.com	Money Market	Low	0.11	0.57	1.78	0.81	0.30	2.03	1.13	0.70	0.37
BOND											
Vanguard Total Bond Market Index Fund Admiral (VBTLX) Seeks to track the performance of a broad, market-weighted bond index. www.vanguard.com	Intermediate-Term Bond (Passive)	Low	0.05	2.94	-0.03	3.57	2.60	4.45	1.98	2.67	3.69
Western Asset Core Plus Bond I (WACPX) Seeks to maximize total return from a high-quality, U.S. domestic core fixed-income portfolio that can be enhanced by allocations to sectors such as high-yield, non-U.S. and emerging market debt. www.leggmason.com	Intermediate-Term Bond	Low	0.45	4.15	-1.49	7.10	4.79	3.71	3.87	3.08	7.43

This fund is your Plan's default investment. Your HRA is automatically invested in this fund until you make a change.

Fund Name (Ticker) Objective	Asset Category	Risk Level	Fund Operating Expense (%)	Average Annual Returns (%)* YTD 2019	Calendar Year 2018	Calendar Year 2017	Calendar Year 2016	1-Year as of 3/31/19	3-Year as of 3/31/19	5-Year as of 3/31/19	10-Year as of 3/31/19
DOMESTIC EQUITY											
Vanguard Total Stock Market Index Fund Admiral (VTSAX) Seeks to track the performance of a benchmark index that measures the investment return of the overall stock market. www.vanguard.com	US All Cap (Passive)	High	0.04	14.04	-5.17	21.17	12.66	8.80	13.52	10.33	16.05
US Core Equity 1 Portfolio I (DFEOX) Seeks to achieve long-term capital appreciation. www.us.dimensional.com	US All Cap	High	0.19	13.79	-7.79	20.89	14.80	5.55	12.79	9.25	16.05
Lazard US Equity Concentrated Portfolio Institutional (LEVIX) Seeks to outperform broad-based securities market indices, such as the S&P 500 Index, the Russell 1000 Index, and the Russell 3000 Index. www.lazardnet.com	US Large Cap	High	0.76	15.67	-6.07	15.49	7.37	8.23	10.01	10.94	15.31
US Small Cap Portfolio I (DFSTX) A market-cap-weighted fund that invests in small-cap U.S. stocks while avoiding the most expensive and least profitable names. www.us.dimensional.com	US Small Cap	High	0.37	12.42	-13.13	11.52	23.53	-0.83	9.73	6.15	16.43
INTERNATIONAL EQUITY											
Vanguard Total International Stock Index Admiral (VTIAX) Seeks to track the performance of a benchmark index that measures the investment return of stocks issued by companies located in developed and emerging markets, excluding the United States. www.vanguard.com	Non-US Equity (Passive)	High	0.11	10.24	-14.43	27.55	4.70	-5.23	8.06	2.77	8.90
American Funds EuroPacific Growth R6 (RERGX) Seeks to provide long-term growth of capital. Invests in companies based chiefly in Europe and the Pacific Basin, ranging from small firms to large corporations. www.americanfunds.com	Non-US Equity	High	0.49	13.20	-14.91	31.17	1.01	-4.66	9.33	4.27	9.94

*Returns greater than one year are annualized.
**Performance information obtained from Morningstar.®

You should carefully consider an investment fund's objectives, risks, fees, charges, and expenses before investing. This and other important information is contained in the prospectus for each fund, which you can get at each fund's respective website as listed under **Fund Name** above. Read the prospectuses carefully before investing.

Past performance does not guarantee future results. Funds are not FDIC insured, are not guaranteed by a bank, and may lose value. Current performance may be higher or lower than the performance shown. The investment return and principal value of an investment will fluctuate so that your account value, when withdrawn, could be worth more or less than its original value. Investment values will fluctuate, and there is no assurance that the objective of any fund will be achieved.

QUESTIONS?

1-844-342-5505

customercare@healthinvesthra.com

healthinvesthra.com

Gallagher

Insurance | Risk Management | Consulting

HealthInvest HRA

INVESTMENT MANAGEMENT
TERMS AND CONDITIONS

The following sets forth the terms and conditions of GFA's obligations as a fiduciary and an ERISA 3(38) investment fiduciary with respect to the services set forth in Addendum D to this Plan Adoption Agreement.

1. **Definitions**.

(a) Assets: All investment assets of the Plan Sponsor's HRA Plan utilizing the HealthInvest standard fund lineup and held by the Master Trustee within the Master Trust on behalf of the Plan and the Participating Trust.

(b) Investment Manager or Manager: Any current or future bank, registered investment advisor, or insurance company selected to manage a portion of the Assets, including any investment manager retained which satisfies the requirements to constitute an "investment manager" pursuant to Section 3(38) of the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated pursuant thereto ("ERISA").

(c) Pooled Investment Fund: Mutual fund, collective investment fund, or any other pooled investment vehicle that is selected or may be select in the future for investing the Assets.

2. **Representations of GFA**. GFA represents and warrants that:

(a) It is a registered investment advisor under the Investment Advisers Act of 1940 and is lawfully empowered to perform or provide the services which, pursuant to this Plan Adoption Agreement and its agreement with the HRA Service Manager, it has agreed to perform or provide;

(b) In performing services described in this Addendum D, it will comply with all applicable laws including ERISA (if the Plan is subject to ERISA).

3. **Form ADV**. In compliance with Rule 204-3(b) promulgated under the Investment Advisers Act, GFA has delivered to the HRA Service Manager the Part 2A Brochure of the Form ADV, covering GFA, as currently in effect. GFA agrees to make available to the HRA Service Manager each year that Assets of the Plan remain in the Master Trust, an updated copy of the Part 2A Brochure as then in effect, which can be provided to the Plan Sponsor via email or on the Plan portal. GFA hereby gives the HRA Service Manager permission and authority to deliver a current copy of the Part 2A Brochure of Form ADV to the Plan Sponsor either in hard copy or electronic form with the Plan Sponsor's welcome packet and to make a copy of the same available to the Plan Sponsor on the HealthInvest HRA Plan website or employer portal.

4. **ERISA Fiduciary, as Applicable**. If the Plan is governed by ERISA, GFA acknowledges that in performing its duties under this Addendum D, that it shall be deemed an

ERISA 3(38) investment manager of the Plan and Master Trust with respect to the services under Addendum D.

5. **No Delegation by GFA or Performance by Individuals**. The Plan Sponsor acknowledges that the services being provided and obligations undertaken hereunder are being provided and undertaken by GFA as an entity and not by any individual officer, director, employee, agent, shareholder or agent of GFA (each a "GFA Individual"). Neither the Master Trust, Participating Trust, Plan Sponsor, Administrator, or HRA Service Manager, nor any fiduciary of the Plan or Master Trust has entered into any agreement to the effect that (i) one or more GFA Individuals, as opposed to GFA, is providing services to the Trust or its fiduciaries, or (ii) the work performed for or advice communicated to the Plan Sponsor or HRA Service Manager by any one or more GFA Individuals is the work or advice of such GFA Individual(s), as opposed to the work or advice of GFA. GFA represents and the Plan Sponsor acknowledges that GFA will not delegate to any GFA Individual GFA's fiduciary obligations and responsibilities owed to the Plan or Master Trust.

6. **This Agreement cannot be assigned by any Party without the consent of the other Parties**.

7. **Notices**. The address for delivery of all communications to GFA shall be:

Gallagher Fiduciary Advisors, LLC
1667 K Street, N.W., Suite 1270
Washington, D.C. 20006
Attention: Area President

With copy to:
Gallagher Fiduciary Advisors, LLC
24 Commerce Street, Suite 1827, Newark, NJ 07102
Attention: Area Assistant Counsel

8. **Liability**. The federal securities laws impose liabilities under certain circumstances on persons who act in good faith, and therefore nothing herein shall in any way constitute a waiver or limitation of any rights which any party may have under any federal securities laws. Except insofar as may be required by ERISA, GFA shall not be liable for liabilities, losses, claims, fees or expenses incurred by the Plan or the Master Trust, or any of its participants or beneficiaries outside scope of this Addendum D.

9. **Litigation Proceedings**. GFA shall not serve as an expert consultant or witness in regard to any civil or criminal judicial proceedings or arbitration or as an expert witness in any such regard, except as may otherwise be agreed in writing by GFA and the HRA Manager, Master Trustee, or Plan Sponsor, as applicable.

ADDENDUM E

HIPAA Business Associate Agreement

Following this page is the executed HIPAA Business Associate Agreement between the Plan Sponsor on behalf of the Plan, as Covered Entity and Gallagher Benefit Services, Inc., as the HRA Service Manager.

HIPAA Business Associate Agreement

Between the County of Riverside and Gallagher Benefit Services

This HIPAA Business Associate Agreement (the "Addendum") supplements and is made part of the Underlying Agreement between the County of Riverside ("County") and Gallagher Benefit Services ("Contractor") and shall be effective as of the date the Underlying Agreement approved by both Parties (the "Effective Date").

RECITALS

WHEREAS, County and Contractor entered into the Underlying Agreement pursuant to which the Contractor provides services to County, and in conjunction with the provision of such services certain protected health information ("PHI") and/or certain electronic protected health information ("ePHI") may be created by or made available to Contractor for the purposes of carrying out its obligations under the Underlying Agreement; and,

WHEREAS, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191 enacted August 21, 1996, and the Health Information Technology for Economic and Clinical Health Act ("HITECH") of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 enacted February 17, 2009, and the laws and regulations promulgated subsequent thereto, as may be amended from time to time, are applicable to the protection of any use or disclosure of PHI and/or ePHI pursuant to the Underlying Agreement; and,

WHEREAS, County is a covered entity, as defined in the Privacy Rule; and,

WHEREAS, to the extent County discloses PHI and/or ePHI to Contractor or Contractor creates, receives, maintains, transmits, or has access to PHI and/or ePHI of County, Contractor is a business associate, as defined in the Privacy Rule; and,

WHEREAS, pursuant to 42 USC §17931 and §17934, certain provisions of the Security Rule and Privacy Rule apply to a business associate of a covered entity in the same manner that they apply to the covered entity, the additional security and privacy requirements of HITECH are applicable to business associates and must be incorporated into the business associate agreement, and a business associate is liable for civil and criminal penalties for failure to comply with these security and/or privacy provisions; and,

WHEREAS, the parties mutually agree that any use or disclosure of PHI and/or ePHI must be in compliance with the Privacy Rule, Security Rule, HIPAA, HITECH and any other applicable law; and,

WHEREAS, the parties intend to enter into this Addendum to address the requirements and obligations set forth in the Privacy Rule, Security Rule, HITECH and HIPAA as they apply to Contractor as a business associate of County, including the establishment of permitted and required uses and disclosures of PHI and/or ePHI created or received by Contractor during the course of performing functions, services and activities on behalf of County, and appropriate limitations and conditions on such uses and disclosures;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in HITECH, HIPAA, Security Rule and/or Privacy Rule, as may be amended from time to time.

   A. "Breach" when used in connection with PHI means the acquisition, access, use or disclosure of PHI in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI, and shall have the meaning given such term in 45 CFR §164.402.

      (1) Except as provided below in Paragraph (2) of this definition, acquisition, access, use, or disclosure of PHI in a manner not permitted by subpart E of the Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following four factors:

         (a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

         (b) The unauthorized person who used the PHI or to whom the disclosure was made;

         (c) Whether the PHI was actually acquired or viewed; and

         (d) The extent to which the risk to the PHI has been mitigated.

      (2) Breach excludes:

         (a) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a

covered entity or business associate, if such acquisition, access or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of the Privacy Rule.

(b) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity, business associate, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted by subpart E of the Privacy Rule.

(c) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

B. "Business associate" has the meaning given such term in 45 CFR §164.501, including but not limited to a subcontractor that creates, receives, maintains, transmits or accesses PHI on behalf of the business associate.

C. "Data aggregation" has the meaning given such term in 45 CFR §164.501.

D. "Designated record set" as defined in 45 CFR §164.501 means a group of records maintained by or for a covered entity that may include: the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or, used, in whole or in part, by or for the covered entity to make decisions about individuals.

E. "Electronic protected health information" ("ePHI") as defined in 45 CFR §160.103 means protected health information transmitted by or maintained in electronic media.

F. "Electronic health record" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff, and shall have the meaning given such term in 42 USC §17921(5).

G. "Health care operations" has the meaning given such term in 45 CFR §164.501.

H. "Individual" as defined in 45 CFR §160.103 means the person who is the subject of protected health information.

I. "Person" as defined in 45 CFR §160.103 means a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

J. "Privacy Rule" means the HIPAA regulations codified at 45 CFR Parts 160 and 164, Subparts A and E.

K. "Protected health information" ("PHI") has the meaning given such term in 45 CFR §160.103, which includes ePHI.

L. "Required by law" has the meaning given such term in 45 CFR §164.103.

M. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS").

N. "Security incident" as defined in 45 CFR §164.304 means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. "Security Rule" means the HIPAA Regulations codified at 45 CFR Parts 160 and 164, Subparts A and C.

P. "Subcontractor" as defined in 45 CFR §160.103 means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

Q. "Unsecured protected health information" and "unsecured PHI" as defined in 45 CFR §164.402 means PHI not rendered unusable, unreadable, or indecipherable to unauthorized persons through use of a technology or methodology specified by the Secretary in the guidance issued under 42 USC §17932(h)(2).

2. **Scope of Use and Disclosure by Contractor of County's PHI and/or ePHI.**

A. Except as otherwise provided in this Addendum, Contractor may use, disclose, or access PHI and/or ePHI as necessary to perform any and all obligations of Contractor under the Underlying Agreement or to perform functions, activities or services for, or on behalf of, County as specified in this Addendum, if such use or disclosure does not violate HIPAA, HITECH, the Privacy Rule and/or Security Rule.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, in accordance with 45 CFR §164.504(e)(2), Contractor may:

1) Use PHI and/or ePHI if necessary for Contractor's proper management and administration and to carry out its legal responsibilities; and,

2) Disclose PHI and/or ePHI for the purpose of Contractor's proper management and administration or to carry out its legal responsibilities, only if:

a) The disclosure is required by law; or,

b) Contractor obtains reasonable assurances, in writing, from the person to whom Contractor will disclose such PHI and/or ePHI that the person will:

i. Hold such PHI and/or ePHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person, or as required by law; and,

ii. Notify County of any instances of which it becomes aware in which the confidentiality of the information has been breached; and,

3) Use PHI to provide data aggregation services relating to the health care operations of County pursuant to the Underlying Agreement or as requested by County; and,

4) De-identify all PHI and/or ePHI of County received by Contractor under this Addendum provided that the de-identification conforms to the requirements of the Privacy Rule and/or Security Rule and does not preclude timely payment and/or claims processing and receipt.

C. Notwithstanding the foregoing, in any instance where applicable state and/or federal laws and/or regulations are more stringent in their requirements than the provisions of HIPAA, including, but not limited to, prohibiting disclosure of mental health and/or substance abuse records, the applicable state and/or federal laws and/or regulations shall control the disclosure of records.

3. **Prohibited Uses and Disclosures.**

A. Contractor may neither use, disclose, nor access PHI and/or ePHI in a manner not authorized by the Underlying Agreement or this Addendum without patient authorization or de-identification of the PHI and/or ePHI and as authorized in writing from County.

B. Contractor may neither use, disclose, nor access PHI and/or ePHI it receives from County or from another business associate of County, except as permitted or required by this Addendum, or as required by law.

C. Contractor agrees not to make any disclosure of PHI and/or ePHI that County would be prohibited from making.

D. Contractor shall not use or disclose PHI for any purpose prohibited by the Privacy Rule, Security Rule, HIPAA and/or HITECH, including, but not limited to 42 USC §17935 and §17936. Contractor agrees:

1) Not to use or disclose PHI for fundraising , unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.514(f) or 45 CFR §164.508;

2) Not to use or disclose PHI for marketing, as defined in 45 CFR §164.501, unless pursuant to the Underlying Agreement and only if permitted by and in compliance with the requirements of 45 CFR §164.508(a)(3);

3) Not to disclose PHI, except as otherwise required by law, to a health plan for purposes of carrying out payment or health care operations, if the individual has requested this restriction pursuant to 42 USC §17935(a) and 45 CFR §164.522, and has paid out of pocket in full for the health care item or service to which the PHI solely relates; and,

4) Not to receive, directly or indirectly, remuneration in exchange for PHI, or engage in any act that would constitute a sale of PHI, as defined in 45 CFR §164.502(a)(5)(ii), unless permitted by the Underlying Agreement and in compliance with the requirements of a valid authorization under 45 CFR §164.508(a)(4). This prohibition shall not apply to payment by County to Contractor for services provided pursuant to the Underlying Agreement.

4. **Obligations of County.**

A. County agrees to make its best efforts to notify Contractor promptly in writing of any restrictions on the use or disclosure of PHI and/or ePHI agreed to by County that may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

B. County agrees to make its best efforts to promptly notify Contractor in writing of any changes in, or revocation of, permission by any individual to use or disclose PHI and/or ePHI, if such changes or revocation may affect Contractor's ability to perform its obligations under the Underlying Agreement, or this Addendum.

C. County agrees to make its best efforts to promptly notify Contractor in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or ePHI.

D. County agrees not to request Contractor to use or disclose PHI and/or ePHI in any manner that would not be permissible under HITECH, HIPAA, the Privacy Rule, and/or Security Rule.

E. County agrees to obtain any authorizations necessary for the use or disclosure of PHI and/or ePHI, so that Contractor can perform its obligations under this Addendum and/or Underlying Agreement.

5. **Obligations of Contractor.** In connection with the use or disclosure of PHI and/or ePHI, Contractor agrees to:

A. Use or disclose PHI only if such use or disclosure complies with each applicable requirement of 45 CFR §164.504(e). Contractor shall also comply with the additional privacy requirements that are applicable to covered entities in HITECH, as may be amended from time to time.

B. Not use or further disclose PHI and/or ePHI other than as permitted or required by this Addendum or as required by law. Contractor shall promptly notify County if Contractor is required by law to disclose PHI and/or ePHI.

C. Use appropriate safeguards and comply, where applicable, with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI and/or ePHI other than as provided for by this Addendum.

D. Mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI and/or ePHI by Contractor in violation of this Addendum.

E. Report to County any use or disclosure of PHI and/or ePHI not provided for by this Addendum or otherwise in violation of HITECH, HIPAA, the Privacy Rule, and/or Security Rule of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410.

F. In accordance with 45 CFR §164.502(e)(1)(ii), require that any subcontractors that create, receive, maintain, transmit or access PHI on behalf of the Contractor agree through contract to the same restrictions and conditions that apply to Contractor with respect to such PHI and/or ePHI, including the restrictions and conditions pursuant to this Addendum.

G. Make available to County or the Secretary, in the time and manner designated by County or Secretary, Contractor's internal practices, books and records relating to the use, disclosure and privacy protection of PHI received from County, or created or received by Contractor on behalf of County, for purposes of determining, investigating or auditing Contractor's and/or County's compliance with the Privacy Rule.

H. Request, use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the request, use or disclosure in accordance with 42 USC §17935(b) and 45 CFR §164.502(b)(1).

I. Comply with requirements of satisfactory assurances under 45 CFR §164.512 relating to notice or qualified protective order in response to a third party's subpoena, discovery request, or other lawful process for the disclosure of PHI, which Contractor shall promptly notify County upon Contractor's receipt of such request from a third party.

J. Not require an individual to provide patient authorization for use or disclosure of PHI as a condition for treatment, payment, enrollment in any health plan (including the health plan administered by County), or eligibility of benefits, unless otherwise excepted under 45 CFR §164.508(b)(4) and authorized in writing by County.

K. Use appropriate administrative, technical and physical safeguards to prevent inappropriate use, disclosure, or access of PHI and/or ePHI.

L. Obtain and maintain knowledge of applicable laws and regulations related to HIPAA and HITECH, as may be amended from time to time.

M. Comply with the requirements of the Privacy Rule that apply to the County to the extent Contractor is to carry out County's obligations under the Privacy Rule.

N. Take reasonable steps to cure or end any pattern of activity or practice of its subcontractor of which Contractor becomes aware that constitute a material breach or violation of the subcontractor's obligations under the business associate contract with Contractor, and if such steps are unsuccessful, Contractor agrees to terminate its contract with the subcontractor if feasible.

6. **Access to PHI, Amendment and Disclosure Accounting.** Contractor agrees to:

A. **Access to PHI, including ePHI.** Provide access to PHI, including ePHI if maintained electronically, in a designated record set to County or an individual as directed by County, within five (5) days of request from County, to satisfy the requirements of 45 CFR §164.524.

B. **Amendment of PHI.** Make PHI available for amendment and incorporate amendments to PHI in a designated record set County directs or agrees to at the request of an individual, within fifteen (15) days of receiving a written request from County, in accordance with 45 CFR §164.526.

C. **Accounting of disclosures of PHI and electronic health record.** Assist County to fulfill its obligations to provide accounting of disclosures of PHI under 45 CFR §164.528 and, where applicable, electronic health records under 42 USC §17935(c) if Contractor uses or maintains electronic health records. Contractor shall:

1) Document such disclosures of PHI and/or electronic health records, and information related to such disclosures, as would be required for County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record in accordance with 45 CFR §164.528.

2) Within fifteen (15) days of receiving a written request from County, provide to County or any individual as directed by County information collected in accordance with this section to permit County to respond to a request by an individual for an accounting of disclosures of PHI and/or electronic health record.

3) Make available for County information required by this Section 6.C for six (6) years preceding the individual's request for accounting of disclosures of PHI, and for three (3) years preceding the individual's request for accounting of disclosures of electronic health record.

7. **Security of ePHI.** In the event County discloses ePHI to Contractor or Contractor needs to create, receive, maintain, transmit or have access to County ePHI, in accordance with 42 USC §17931 and 45 CFR §164.314(a)(2)(i), and §164.306, Contractor shall:

A. Comply with the applicable requirements of the Security Rule, and implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that Contractor creates, receives, maintains, or transmits on behalf of County in accordance with 45 CFR §164.308, §164.310, and §164.312;

B. Comply with each of the requirements of 45 CFR §164.316 relating to the implementation of policies, procedures and documentation requirements with respect to ePHI;

C. Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;

D. Protect against any reasonably anticipated uses or disclosures of ePHI that are not permitted or required under the Privacy Rule;

E. Ensure compliance with the Security Rule by Contractor's workforce;

F. In accordance with 45 CFR §164.308(b)(2), require that any subcontractors that create, receive, maintain, transmit, or access ePHI on behalf of Contractor agree through contract to the same restrictions and requirements contained in this Addendum and comply with the applicable requirements of the Security Rule;

G. Report to County any security incident of which Contractor becomes aware, including breaches of unsecured PHI as required by 45 CFR §164.410; and,

H. Comply with any additional security requirements that are applicable to covered entities in Title 42 (Public Health and Welfare) of the United States Code, as may be amended from time to time, including but not limited to HITECH.

8. **Breach of Unsecured PHI.** In the case of breach of unsecured PHI, Contractor shall comply with the applicable provisions of 42 USC §17932 and 45 CFR Part 164, Subpart D, including but not limited to 45 CFR §164.410.

A. **Discovery and notification.** Following the discovery of a breach of unsecured PHI, Contractor shall notify County in writing of such breach without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, except as provided in 45 CFR §164.412.

1) **Breaches treated as discovered.** A breach is treated as discovered by Contractor as of the first day on which such breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor, which includes any person, other than the person committing the breach, who is an employee, officer, or other agent of Contractor (determined in accordance with the federal common law of agency).

2) **Content of notification.** The written notification to County relating to breach of unsecured PHI shall include, to the extent possible, the following information if known (or can be reasonably obtained) by Contractor:

a) The identification of each individual whose unsecured PHI has been, or is reasonably believed by Contractor to have been accessed, acquired, used or disclosed during the breach;

b) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

c) A description of the types of unsecured PHI involved in the breach, such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved;

d) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

e) A brief description of what Contractor is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and,

f) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

B. **Cooperation.** With respect to any breach of unsecured PHI reported by Contractor, Contractor shall cooperate with County and shall provide County with any information requested by County to enable County to fulfill in a timely manner its own reporting and notification obligations, including but not limited to providing notice to individuals, prominent media outlets and the Secretary in accordance with 42 USC §17932 and 45 CFR §164.404, §164.406 and §164.408.

C. **Breach log.** To the extent breach of unsecured PHI involves less than 500 individuals, Contractor shall maintain a log or other documentation of such breaches and provide such log or other documentation on an annual basis to County not later than fifteen (15) days after the end of each calendar year for submission to the Secretary.

D. **Delay of notification authorized by law enforcement.** If Contractor delays notification of breach of unsecured PHI pursuant to a law enforcement official's statement that required notification, notice or posting would impede a criminal investigation or cause damage to national security, Contractor shall maintain documentation sufficient to demonstrate its compliance with the requirements of 45 CFR §164.412.

E. **Payment of costs.** With respect to any breach of unsecured PHI caused solely by the Contractor's failure to comply with one or more of its obligations under this Addendum and/or the provisions of HITECH, HIPAA, the Privacy Rule or the Security Rule, Contractor agrees to pay any and all costs associated with providing all legally required notifications to individuals, media outlets, and the Secretary. This provision shall not be construed to limit or diminish Contractor's obligations to indemnify, defend and hold harmless County under Section 9 of this Addendum.

F. **Documentation.** Pursuant to 45 CFR §164.414(b), in the event Contractor's use or disclosure of PHI and/or ePHI violates the Privacy Rule, Contractor shall maintain documentation sufficient to demonstrate that all notifications were made by Contractor as required by 45 CFR Part 164, Subpart D, or that such use or disclosure did not constitute a breach, including Contractor's completed risk assessment and investigation documentation.

G. **Additional State Reporting Requirements.** The parties agree that this Section 8.G applies only if and/or when County, in its capacity as a licensed clinic, health facility, home health agency, or hospice, is required to report unlawful or unauthorized access, use, or disclosure of medical information under the more stringent requirements of California Health & Safety Code §1280.15. For purposes of this Section 8.G, "unauthorized" has the meaning given such term in California Health & Safety Code §1280.15(j)(2).

1) Contractor agrees to assist County to fulfill its reporting obligations to affected patients and to the California Department of Public Health ("CDPH") in a timely manner under the California Health & Safety Code §1280.15.

2) Contractor agrees to report to County any unlawful or unauthorized access, use, or disclosure of patient's medical information without unreasonable delay and no later than two (2) business days after Contractor detects such incident. Contractor further agrees such report shall be made in writing, and shall include substantially the same types of information listed above in Section 8.A.2 (Content of Notification) as applicable to the unlawful or unauthorized access, use, or disclosure as defined above in this section, understanding and acknowledging that the term "breach" as used in Section 8.A.2 does not apply to California Health & Safety Code §1280.15.

9. **Hold Harmless/Indemnification.**

A. Contractor agrees to indemnify and hold harmless County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives from any liability whatsoever, based or asserted upon any services of Contractor, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Addendum, including but not limited to property damage, bodily injury, death, or any other element of any kind or nature whatsoever arising from the performance of Contractor, its officers, agents, employees, subcontractors, agents or representatives from this Addendum. Contractor shall defend, at its sole expense, all costs and fees, including but not limited to attorney fees, cost of investigation, defense and settlements or awards, of County, all Agencies, Districts, Special Districts and Departments of County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents or representatives in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by Contractor, Contractor shall, at their sole cost, have the right to use counsel of their choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes Contractor's indemnification to County as set forth herein. Contractor's obligation to defend, indemnify and hold harmless County shall be subject to County having given Contractor written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at Contractor's expense, for the defense or settlement thereof. Contractor's obligation hereunder shall be satisfied when Contractor has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Addendum shall in no way limit or circumscribe Contractor's obligations to indemnify and hold harmless County herein from third party claims arising from issues of this Addendum.

D. In the event there is conflict between this clause and California Civil Code §2782, this clause shall be interpreted to comply with Civil Code §2782. Such interpretation shall not relieve the Contractor from indemnifying County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Addendum, this indemnification shall only apply to the subject issues included within this Addendum.

10. **Term.** This Addendum shall commence upon the Effective Date and shall terminate when all PHI and/or ePHI provided by County to Contractor, or created or received by Contractor on behalf of County, is destroyed or returned to County, or, if it is

infeasible to return or destroy PHI and/ePHI, protections are extended to such information, in accordance with section 11.B of this Addendum.

11. **Termination.**

A. **Termination for Breach of Contract.** A breach of any provision of this Addendum by either party shall constitute a material breach of the Underlying Agreement and will provide grounds for terminating this Addendum and the Underlying Agreement with or without an opportunity to cure the breach, notwithstanding any provision in the Underlying Agreement to the contrary. Either party, upon written notice to the other party describing the breach, may take any of the following actions:

1) Terminate the Underlying Agreement and this Addendum, effective immediately, if the other party breaches a material provision of this Addendum.

2) Provide the other party with an opportunity to cure the alleged material breach and in the event the other party fails to cure the breach to the satisfaction of the non-breaching party in a timely manner, the non-breaching party has the right to immediately terminate the Underlying Agreement and this Addendum.

3) If termination of the Underlying Agreement is not feasible, the breaching party, upon the request of the non-breaching party, shall implement, at its own expense, a plan to cure the breach and report regularly on its compliance with such plan to the non-breaching party.

B. **Effect of Termination.**

1) Upon termination of this Addendum, for any reason, Contractor shall return or, if agreed to in writing by County, destroy all PHI and/or ePHI received from County, or created or received by the Contractor on behalf of County, and, in the event of destruction, Contractor shall certify such destruction, in writing, to County. This provision shall apply to all PHI and/or ePHI which are in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of PHI and/or ePHI, except as provided below in paragraph (2) of this section.

2) In the event that Contractor determines that returning or destroying the PHI and/or ePHI is not feasible, Contractor shall provide written notification to County of the conditions that make such return or destruction not feasible. Upon determination by Contractor that return or destruction of PHI and/or ePHI is not feasible, Contractor shall extend the protections of this Addendum to such PHI and/or ePHI and limit further uses and disclosures of such PHI and/or ePHI to those purposes which make the return or destruction not feasible, for so long as Contractor maintains such PHI and/or ePHI.

12. **General Provisions.**

A. **Retention Period.** Whenever Contractor is required to document or maintain documentation pursuant to the terms of this Addendum, Contractor shall retain such documentation for 6 years from the date of its creation or as otherwise prescribed by law, whichever is later.

B. **Amendment.** The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for County to comply with HITECH, the Privacy Rule, Security Rule, and HIPAA generally.

C. **Survival.** The obligations of Contractor under Sections 3, 5, 6, 7, 8, 9, 11.B and 12.A of this Addendum shall survive the termination or expiration of this Addendum.

D. **Regulatory and Statutory References.** A reference in this Addendum to a section in HITECH, HIPAA, the Privacy Rule and/or Security Rule means the section(s) as in effect or as amended.

E. **Conflicts.** The provisions of this Addendum shall prevail over any provisions in the Underlying Agreement that conflict or appear inconsistent with any provision in this Addendum.

F. **Interpretation of Addendum.**

1) This Addendum shall be construed to be part of the Underlying Agreement as one document. The purpose is to supplement the Underlying Agreement to include the requirements of the Privacy Rule, Security Rule, HIPAA and HITECH.

2) Any ambiguity between this Addendum and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, Security Rule, HIPAA and HITECH generally.

G. **Notices to County.** All notifications required to be given by Contractor to County pursuant to the terms of this Addendum shall be made in writing and delivered to the County both by fax and to both of the addresses listed below by either registered or certified mail return receipt requested or guaranteed overnight mail with tracing capability, or at such other address as County may hereafter designate. All notices to County provided by Contractor pursuant to this Section shall be deemed given or made when received by County.

County HIPAA Privacy Officer: HIPAA Privacy Manager

County HIPAA Privacy Officer Address: 26520 Cactus Avenue,
Moreno Valley, CA 92555

County HIPAA Privacy Officer Phone Number: (951) 486-6471

Attachment E

HealthInvest HRA Plan Coverage Document
Limited HRA Coverage

Effective as of January 1, 2020

HealthInvest HRA
Plan Coverage Document

Limited HRA Coverage
Effective as of January 1, 2020

Limited Purpose or Limited Scope/Excepted Benefits

ARTICLE I.
General Provisions

1.1 Name. The name of the Plan shall be the HealthInvest Health Reimbursement Arrangement "HRA" Plan (the "HealthInvest HRA Plan") of the Plan Sponsor and each Participating Employer. This Plan Coverage Document of the HealthInvest HRA Plan sets forth the terms and conditions for coverage that provides reimbursement of certain forms of limited coverage for qualified IRC §213(d) expenses and is referred to as the "Limited HRA Plan" or "Limited HRA Coverage." The HealthInvest HRA Plan may include one or more HRA plans or forms of HRA coverage from time to time the terms of which will be set forth and governed by a separate Plan Coverage Document applicable thereto.. When used herein, the terms "Plan" or "HRA Plan" or "HealthInvest HRA Plan" shall refer to this Limited HRA Plan either individually or collectively with other plans or forms of plan coverage included with the HealthInvest HRA Plan as the context indicates or requires.

1.2 Plan Documents. The HealthInvest HRA Plan Documents shall consist of all HealthInvest HRA Plan Coverage Documents, as applicable, the most current version of the Summary Plan Description, as the same may be amended from time to time, the Plan Adoption Agreement, the Master Trust, the Master Trust Adoption Agreement, the Trust Agreement, and, with respect to a Participating Employer, the applicable Employer Participation Agreement, and (with respect to a particular Participant) the individual Participant Enrollment File, all such documents collectively referred to as the "HealthInvest HRA Plan Documents". The Plan shall consist of the HealthInvest HRA Plan Documents and any Wrap Plan Documents of the Plan Sponsor. This Plan Coverage Document, any applicable Employer Participation Agreement, the individual Participant Enrollment File, the Plan Adoption Agreement, and any Wrap Documents set forth the terms and conditions for the HealthInvest Limited HRA Coverage. This Plan Coverage Document hereby amends, restates, and replaces all prior Plan Coverage Document versions governing HealthInvest Limited HRA coverage.

1.3 Definitions and Interpretation of Plan Documents.

1.3.1 Definitions. Defined terms used in this Plan Document and not otherwise defined herein are found in Appendix A hereto.

1.3.2 Terms Incorporated by Reference. Capitalized terms used herein and not defined herein shall have the meaning ascribed to such terms in the other HealthInvest HRA Plan Documents. In the event of a conflict in the definition ascribed to any term in more than one HealthInvest HRA Plan Document, the conflict shall be resolved based upon

the definition ascribed to such term in the document under which the provision in question references such term, and if not defined therein, then by reference to the definition ascribed to such term in the other Plan Documents as follows: first by reference to the Wrap Documents, then to the Master Trust, then to the Master Trust Adoption Agreement, then to this Plan document version, then to the Summary Plan Description, then to the Plan Adoption Agreement, then to the applicable Employer Participation Agreement, then to the applicable Enrollment File, then to the other Plan document versions, and then to the Trust Agreement..

1.3.3 Conflict in General Terms of Plan Documents. Collectively, the HealthInvest HRA Plan Documents are all parts of a single, integrated employee benefit system and shall be construed together. Except as specifically provided in Section 1.3.2, in the event of any conflict between the terms of this Plan document version and one or more of the Plan Documents, such conflict shall be resolved first by reference to the Wrap Documents, then to the Master Trust, then to the Master Trust Adoption Agreement, then to this Plan document version, then to the Summary Plan Description, then to the Plan Adoption Agreement, then to the applicable Employer Participation Agreement, then to the applicable Enrollment File, then to the other Plan document versions, and then to the Trust Agreement.

1.3.4 Construction and Interpretation of Plan Documents. Headings used in this Plan are inserted for convenience of reference only, and are not to be used in interpreting the provisions. References to or definition of any document, instrument or agreement, unless expressly noted otherwise shall mean the same as amended, restated, supplemented, or otherwise modified from time to time. The words "including," includes," and "include" are used to mean without limitation. The word "or" is not exclusive. Wherever from the context it appears appropriate, each term stated in either the singular or plural shall include the singular and the plural, and pronouns stated in the masculine, feminine, or neuter gender shall include the masculine, feminine, and neuter genders.

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 Coverages offered under this Plan in accordance with the terms and conditions of the Plan, policies and procedures of the Administrator, and applicable law. The HealthInvest HRA Plan may add additional types of Limited HRA Coverages or remove Limited HRA Coverages as permitted or required by applicable law or as determined by the Administrator in accordance with the terms of the Plan Documents. Claims and recordkeeping administration for this Limited HRA Plan and other Plan coverages included in the HealthInvest HRA Plan are administered under a contract separate from claims administration for the GHP or other benefit plans of the Plan Sponsor and Participating Employers. During any period in which the Participant is automatically subject to or has elected coverage under this Limited HRA Plan, the Participant shall have the right to decline or revoke coverage under the Limited HRA Plan by notifying the HRA Service Manager or other Plan Representative by phone or in writing.

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 benefits that are considered Excepted Benefits as provided in 26 C.F.R. §54.9831-1 (c)(3)(i)-(iv), and 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 (iii) is not required to be reported on IRS Form 1095-B pursuant to IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. §54.9831-1(c)(3)(viii).

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 benefits are considered Excepted Benefits as provided in 26 C.F.R. §54.9831-1(c)(3)(i)-(iv), and further described under IRS Notice 2015-87 Q&A-5 and 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 (iii) is not required to be reported on IRS Form 1095-B pursuant to IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. §54.9831-1(c)(3)(viii).

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, subject to the Mandates (ii) may preclude a Participant from eligibility for an IRC §36B premium tax credit (iii) will be reported on IRS Form 1095-B as required by IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. §54.9831-1(c)(3)(viii).

ARTICLE II.
Participation

2.1 Eligibility; Commencement of Participation. Subject to the limitations of this Article II, and subject to the eligibility provisions of the Wrap Documents, Employer policies, applicable collective bargaining agreements (if applicable), other legal or contractual obligations of the Employer, the Plan Adoption Agreement, and the Employer Participation Agreement, an Employee is eligible to become 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 Eligibility 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 a Dependent fails to meet the requirements for coverage and eligibility for Benefits under the In-service Benefits Plan or the Post-separation Benefits Plan.

2.2 **Duration of Participation.** Once a Participant becomes Claims-Eligible under the Plan, the Participant's active status with respect to any Participant Account shall exist for so long as there is a positive account balance in such Participant Account, and thereafter, for such period as determined under the policies and procedures of the Administrator ("Account Closure Period"), but not to exceed two (2) years. If a Participant Account remains exhausted for the Account Closure Period, the Participant's active status with respect to such Account shall terminate after such Account Closure Period in accordance with the Plan's policies and procedures. A Participant who has lost his or her active status with respect to any Participant Account may subsequently become a Participant in the Plan and Claims-Eligible as prescribed in Section 2.1. During any Account Closure Period for any Participant Account a Participant may or may not receive statements or other plan communications with respect to such Participant Account but will remain Claims-Eligible.

2.3 **Nondiscrimination.** The Plan is intended to comply with all nondiscrimination laws applicable to eligibility under, contributions to, and Benefits of, the Plan (including any such rules prescribed by IRC §105(h)).

ARTICLE III.
Funding or Allocation of Benefits

3.1 **Contributions.** The Employer, or the Plan Sponsor on behalf of the Employer, may make one or more contributions to the Plan, or transfer assets from other benefit plans, with respect to eligible Employees pursuant to the terms of Wrap Documents, collective bargaining agreements, Employer policies, or other legal or contractual obligations of the Employer. Contributions or transfers to the Plan shall be specifically allocated to one or more Participant Accounts or maintained in an Employer Account for the purpose of paying Benefits or for other purposes permitted by and described in the Plan Documents. The Plan may accept amounts transferred from another welfare benefit plan maintained for the benefit of Employees, provided that no such transfer will be permitted based on the election or direction of any individual Employee or that would otherwise cause the Plan to be treated as anything other than a health reimbursement arrangement qualifying under IRC §§105 and 106. Except for any contributions that constitute COBRA continuation premiums paid by Employees, or Dependents, no individual Employee contributions or direct or indirect salary reduction contributions elected by individual Employees will be permitted. All deposits, transfers, and other contributions (including COBRA contributions from Participants and Dependents, if any) shall be on the terms acceptable to the Administrator and pursuant to rules, policies and procedures established by the Administrator.

3.2 **Administration of Contributions.** All contributions and other amounts transferred to the Plan shall be held in a custodial account by, or on behalf of the Plan and invested, administered and distributed in accordance with the terms of the Plan. Neither the Administrator, HRA Service Manager, nor any other of the Plan Representatives shall be under any duty to inquire into the timeliness or correctness of the amounts contributed to the Plan, or to confirm or enforce the payment of contributions to the Plan or terms of any Wrap Documents, collective bargaining agreement, policy, or other agreements or obligations regarding the terms of eligibility to participate in the Plan or amounts to be contributed on behalf of a Participant. No provision of this Plan shall be construed as requiring the Employer or Plan Sponsor to make or continue to

make contributions to the Plan. Nothing in this Plan shall entitle the Administrator, HRA Service Manager, Plan Representatives, or Participants to inquire into or demand the right to inspect the books of the Employer.

3.3 Use of Plan Assets. Except as otherwise provided herein or in the Plan Adoption Agreement, Plan assets shall be used exclusively to pay Benefits and obligations under the Plan and to defray reasonable expenses of administering the Plan, including to the fullest extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Plan, the Plan Sponsor (in its capacity as Administrator or Plan Sponsor), the Employer, or Participants, that may be paid through reasonable fees and assessments from Plan assets, including Participant Accounts.

3.4 Limitation on Rights. Except as otherwise provided herein and in the Plan Adoption Agreement, no person shall have any rights with respect to Plan assets allocable to any Participant Account except the rights of Participants, Dependents, and any other persons entitled to receive Benefits under such Participant Account in accordance with the terms, and subject to the limitations of, the Plan and applicable law, and no such person shall be considered to have any legal or equitable ownership interest in any assets of the Plan. The rights of a Participant, Dependent, or any other person entitled to receive Benefits from a Participant Account, shall not be subject to assignment or alienation, either by voluntary or involuntary act of the person or by operation of law and shall not be subject to attachment, execution, garnishment, or any other legal or equitable process except to the extent required by law.

ARTICLE IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Plan to reflect the contributions, income, losses, increases and decreases for expenses or benefit payments attributable to each Participant Account and Employer Account, and for the Plan in the aggregate.

4.2 Receipt and Allocation of Contributions and Transfers. Contributions and transfers will be credited as received by the Plan and are to be allocated based upon instructions from the Employer or Plan Sponsor. If a complete Enrollment File or investment election instructions have not been submitted for any amount allocated by the Participating Employer or Plan Sponsor to a Participant Account, the contribution may be allocated to a non-interest bearing account for unallocated funds or to one or more default investment funds designated by the Plan Sponsor until such time as a complete Enrollment File or investment election instructions are submitted by the Participant. If any portion of any contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Participating Employer or Plan Sponsor, the contribution may be allocated to a non-interest bearing account for unallocated funds or to one or more default investment funds until such time as further instructions are received from the Employer or Plan Sponsor. Upon determining that any portion of any contribution is not allocable to a specific Participant Account or an Employer Account, the HRA Service Manager shall notify the Participating Employer or Plan Sponsor within five (5) business days following the HRA Service Manager's reasonable and customary efforts to obtain such

instructions. The Participating Employer or Plan Sponsor shall provide the HRA Service Manager with written instruction on how to handle such contributions within five (5) business days of receiving such request. The Plan Sponsor's or Participating Employer's instructions shall direct the HRA Service Manager to distribute the non-allocated portion of these contributions in a manner deemed appropriate at the sole discretion of the Plan Sponsor or the Participating Employer, provided that such instructions are not inconsistent with the rules governing the Trust Agreement or the Plan Sponsor's participation in the Master Trust. The written instructions from the Plan Sponsor or Participating Employer may include, but are not limited to: (1) the instruction to place unallocated contributions into a non-interest bearing account for unallocated funds or to one or more default investment funds designated by the Plan Sponsor, as appropriate based on existing circumstances; or (2) the instruction to return the unallocated contribution to the Participating Employer. If the HRA Service Manager does not receive direction from the Employer or the Plan Sponsor within the timeframes indicated above, the HRA Service Manager shall have the right to return such funds to the Employer or Plan Sponsor, as applicable. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior benefit plan on behalf of an Employee for whom an Enrollment File is not submitted will not be returned to the Employer and will be treated as directed by the Plan Sponsor or Employer in writing and in accordance with the policies and procedures established by the Administrator.

4.3 Accounting Steps. The HRA Service Manager shall:

4.3.1 Allocate and credit any contribution to this Plan to a Participant Account or an Employer Account within two (2) business days of receipt of an electronic contribution or transfer and within five (5) business days of receipt of a paper check contribution or transfer.

4.3.2 At the end of each Valuation Period, adjust each Participant Account and Employer Account upward or downward, by an amount equal to the net income or loss accrued under this Plan with respect to such Account.

4.3.3 At the end of each Benefit Payment Period, charge to each Participant Account payments or distributions made under this Plan to or for the benefit of the Participant for Participant Accounts or the Employer for Employer Accounts.

4.3.4 Charge to each Participant Account and Employer Account applicable fees that are allocable to the account that have not been charged previously.

4.4 Investment of Participant Accounts and Employer Accounts. The Plan will provide one or more paper forms or other online or mobile application methods by which an Employer or Participant may direct the investment options into which funds in any Employer Account or Participant Account shall be invested. For Participant Accounts designated by the Plan Sponsor for Participant-directed investing, each Participant shall be responsible for the investment decisions for his or her Participant Account and shall elect one or more investment options into which funds contributed to his or her Participant Account or Accounts will be invested. For Employer Accounts designated by the Plan Sponsor or Participating Employer for Employer-

directed investing, the Employer shall be responsible for the investment decisions for its Employer Account and shall elect one or more investment options into which the funds contributed to the Employer Account will be invested, subject to any investment limitations prescribed by applicable law. Investment elections shall be made and changed in accordance with procedures established for the Plan, as such procedures may be amended from time to time. In the event an Enrollment File has been received with respect to a Participant but no investment election has been made with respect to the Participant Account, or no investment election has been made by the Employer with respect to an Employer Account, that Account shall be invested in one or more default investment options. The Plan shall not be required to maintain separate investments with respect to separate Participant Accounts or Employer Accounts, and all Plan assets may be invested in an omnibus account with securities registered in the name of a nominee, trustee, custodian, or transfer agent as permitted by the Plan Adoption Agreement. Notwithstanding the foregoing, the HRA Service Manager, on behalf of the Administrator, shall maintain separate and distinct sub-accounting records for each Participant Account and Employer Account so that such accounts will be credited with divided interests in the specific investments allocable thereto.

4.5 Use of Participant Accounts. Amounts credited to a Participant Account shall be available to provide Benefits with respect to the Participant or his or her Dependents at such times as specified in the Plan Adoption Agreement and other Plan Documents, provided the Participant has satisfied any vesting and claims-eligibility requirements, and the HRA Service Manager shall be entitled to rely on verification from the Employer or the Participant that such requirements have been met. Any amounts allocated to a Participant Account that are forfeited pursuant to the terms of the Plan Documents will be reallocated to other Participant Accounts or an Employer Account or returned to the Employer, as provided in the Plan Adoption Agreement and permitted by the applicable Trust Agreement, and applicable law.

4.6 Use of Employer Accounts. Amounts credited to an Employer Account are to be applied in any manner permitted under the Plan Adoption Agreement, Trust Agreement, and applicable law.

4.7 Splitting Participant Account Upon Court Order or Agreement. To the extent permitted 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 decree and subject to the policies and procedures of the HRA Service Manager; provided, however, the Administrator or HRA Service Manager shall have the right not to split such account if the splitting of accounts upon divorce could result in disqualification of or adverse tax consequences for the Plan or Trust. The HRA Service Manager may develop policies and procedures to value, report, withhold, and pay applicable taxes or other fees and charges in accordance with the Plan Documents and applicable law, and to the extent permitted by law, the same shall be conclusive and binding upon the Participant and his or her former Spouse.

4.8 Notify the Plan of Errors within Ninety (90) Days. Participants, the Plan Sponsor, and the Employer should regularly review account information and immediately report any potential errors to the Plan. Participants, Plan Sponsors, and Employers must notify the Plan of an account error within ninety (90) days from the date the potential account error (a) is viewed by the applicable Participant or the Plan Sponsor or Employer online through the Plan portal or (b)

appears on an account statement or other report received by the applicable Participant or the Plan Sponsor or Employer, whichever occurs first ("Notification Period"). The Plan Sponsor or Employer may, but shall not have an obligation to, notify the Plan of any error relating to a Participant Account, with it being the sole responsibility of the Participant to regularly review his or her account and notify the Plan of any errors. Notification of any potential errors should be in writing in accordance with Section 4.8.1 below.

4.8.1. Contents of Error Notification. Written notice of any potential account error must include: (1) the name of the Plan Sponsor and/or 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 the Plan Sponsor or Employer believes it to be an error.

4.8.2 Investigation of Error; Corrective Action. The Administrator or its designee will perform a timely investigation of any error notifications. The affected parties 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 HRA Service Manager. Correction of any errors will be applied prospectively and, retroactively for any losses incurred during the Notification Period defined by this Section 4.8, including any investment losses, if such losses are the direct result of the negligent error or omission on the part of the Plan or its representatives. However, neither the Plan, nor any Plan Representative shall be liable for losses incurred by a Participant or the Plan Sponsor or Employer, as applicable, after expiration of the Notification Period.

4.9 Reliance upon Data and Information from Participants, Plan Sponsor, and Employer. It is the responsibility of Participants and the Plan Sponsor or 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 the Plan Sponsor or Employer as true and correct. The Plan and its agents are not responsible for any errors made by a Participant or the Plan Sponsor 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 the Plan's reliance upon incorrect data or information submitted by a Participant or the Plan Sponsor or Employer. If a Participant or the Plan Sponsor or Employer discovers that information or data submitted to the Plan was incorrect, it is the responsibility of that Participant or the Plan Sponsor of Employer to timely notify the Plan in writing and correct the information or data.

4.10 Forfeited or Unclaimed Accounts. In an effort to preserve Participant Accounts from becoming unclaimed or forfeited, the HRA Service Manager may implement policies and procedures to locate Participants. In each instance for which a Participant (1) has combined account balances greater than $250 and (2) for a period of at least six months has met the conditions set forth under Sections 4.10.2.1 – 4.10.2.4 and has otherwise been unreachable by the Plan, the HRA service Manager may engage third-party services to locate the Participant. Reasonable fees and expenses incurred by the HRA Service Manager in its effort to locate a Participant under the foregoing circumstances may be charged against one Participant Account up to an amount not to exceed the lower of $100 or 20% of the combined account balances. Notwithstanding the above, if a positive balance remains in any Participant Account under any of the following circumstances, the remaining balance in such Participant Account shall be forfeited and applied as directed in the Plan Adoption Agreement or as otherwise directed by the Plan Sponsor or Employer, in all cases

to the fullest extent permitted by applicable law and subject to the rules and policies and procedures established by the HRA Service Manager:

4.10.1 After the death of the Participant and at a time when there are no Dependents or other persons entitled to receive Benefits from such Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer) as described in Section 5.3.

4.10.2 If, in accordance with the policies and procedures of the Plan, the HRA Service Manager has determined the participant is not locatable and, during a continuous period equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for the Participant Account and (ii) three years, the following conditions exist:

4.10.2.1 Such Participant Account is vested and Claims-Eligible;

4.10.2.2 No contributions to or withdrawals from the Participant Account have occurred;

4.10.2.3 No communications or other expressions of interest have been received by the Plan from or on behalf of the Participant; and

4.10.2.4 During such period at least two communications from the Plan to the Participant have been returned as undeliverable.

4.10.3 After the Participant for whom such Participant Account is established shall have been unable to submit claims for reimbursement pursuant to Section 5.1.2 hereof for at least three years from the Claims Eligibility Date for such Participant because the Plan has not received a complete Enrollment File for such Participant.

4.10.4 Any other circumstance specified in this Plan or the Plan Adoption Agreement that results in the forfeiture of the account balance in any Participant Account.

ARTICLE V.
Qualified Health Care Expenses and Limited HRA Coverage

5.1 Benefits for Qualified Health Care Expenses. Limited HRA coverage includes reimbursement for medical care expenses as defined by IRC §213(d) and IRC §106(f) 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 the Plan Documents, applicable law, or as otherwise provided in policies and procedures of the Administrator or HRA Service Manager. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under the terms of this Plan

Document version. Benefits may include (but are not limited to) Premium Reimbursements 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 healthcare flexible spending account which provides the same type of benefits as are covered under this Plan must exhaust benefits under the IRC §125 healthcare flexible spending account plan prior to filing a request for 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, elect, or 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 HealthInvest HRA 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 Administrator in accordance with applicable law and the terms of the Plan Documents. During any period in which the Participant is automatically subject to or has elected coverage under this Limited HRA Plan, the Participant shall have the right to decline or revoke coverage under the Limited HRA Plan by notifying the HRA Service Manager or other Plan Representative by phone or in writing.

5.1.2.1 Limited-Scope/Excepted Benefits Coverage. Coverage for Participants and their Dependents under this Plan is based upon either (i) ineligibility for coverage under the In-service Benefits Plan or Post-separation Benefits Plan or (ii) an Employer's Plan design to provide Limited HRA Coverage for Participants with an account under the Post-separation Benefits Plan while they are currently-employed with the Employer or (iii) an election of Limited HRA Coverage for those Participants eligible for coverage under the Standard HRA Plan or Post-separation HRA Plan 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 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) and eligible for coverage under the Standard HRA Plan or Post-separation HRA Plan 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 Document, Participants are entitled to Limited HRA coverage for Qualified Health Care Expenses incurred on or after the date they become Claims-Eligible, provided that the Administrator may require, as a condition to the payment of Benefits, any information necessary for the Plan or 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).

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

5.1.5 Premium-Only and Other Limited-Use Accounts. Pursuant to an election of the Plan Sponsor in the Plan Adoption Agreement, the Plan Sponsor may limit one or more Participant Accounts of any group of Participants covered by this Limited HRA Plan to Premium Reimbursements only. In addition, the Plan Sponsor may, pursuant to an election or amendment of the Plan Adoption Agreement, impose any other limitations or restrictions on the payment of Benefits as necessary or desirable to coordinate with other benefit plans of Participants or to comply with applicable laws or regulations.

5.16 COBRA. Participants or Dependents have a right to continue to make contributions and/or receive Benefits under this Plan for a specified time period if such rights are lost due to certain qualifying events, as prescribed by COBRA. COBRA continuation coverage for certain qualifying events is dependent on the Plan receiving notification of qualifying events within certain time periods as prescribed by COBRA. The Plan will administer continuation of COBRA using policies and procedures required or permitted by COBRA.

5.2 Health Care Debit Cards. Participants in the HRA Plan may, subject to the procedures established by the Administrator, use the Card(s) provided by the Administrator for payment of Benefits, subject to the provisions below.

5.2.1 Each Participant, by participating in the Card Program and by using the Card(s), certifies that such Card shall only be used for Benefits and that any Benefit paid with the Card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

5.2.2 The Card shall be issued upon the Participant becoming Claims-Eligible, and is valid until reissued or replaced and for so long as the Participant remains a Participant in the Plan. The dollar amount of coverage available on the Card shall be subject to policies and procedures of the Administrator. Participant shall not use the Card to pay claims in excess of the dollar amount available on the Card.

5.2.3 The Cards shall only be used for permitted Benefits.

5.2.4 Participant shall be subject to the terms and conditions of the cardholder agreement, which shall be distributed with the Card.

5.2.5 Purchases made with the Cards shall be subject to the substantiation requirements of the Administrator. The Administrator, in its sole discretion, shall adopt procedures to ensure that amounts paid with the Card qualify as eligible Benefits under the Plan. Substantiation may be accomplished in accordance with policies and procedures of the Administrator, including without limitation, by Participant's submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase, and the amount. Some charges shall be considered substantiated at or after the time of the Card charge by the nature of the charge and information collected at the time of the charge. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously substantiated as to amount, provider, and time period. At the point of sale, the service provider or merchant can provide or make available to the Administrator information to substantiate the charge. All charges not automatically adjudicated shall be conditional, pending confirmation and substantiation.

5.2.6 Participants shall maintain records to substantiate payments of Benefits made with Cards. If the Card is used to pay an expense that is not automatically adjudicated or otherwise independently verified without additional documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Administrator to verify that the amount was an eligible Benefit. If the Participant fails to provide information to satisfy the Administrator that amounts paid by use of the Card are eligible Card Services, the Administrator may, in its discretion, make the Plan whole by taking whatever action it deems appropriate to require the Participant to repay the amount that has not been verified, including:

(a) requesting the Participant to reimburse the Plan for the amount that has not been verified;

(b) offsetting future reimbursement of claims by the amount paid by use of the Card that has not been verified;

(c) suspending the activation on the Participant's Card; and

(d) suspending the Participant's eligibility to use the Card and participate in the Plan.

If the Administrator's correction efforts prove unsuccessful, the Participant remains indebted to the Plan for the amount of the payment that has not been verified. In that event, and consistent with its business practices, the Plan may treat the amount that has not been verified as it would any other business indebtedness. If the payment is not recovered within the timeframes specified in the policies and procedures of the Administrator, then the Plan may forgive the indebtedness, in which case the payment shall be reported as taxable income for the year in which the indebtedness is forgiven.

5.2.7 The Administrator, in its sole discretion, may adopt such other rules that it deems appropriate to govern the use of the Card to pay eligible Benefits (*e.g.*, establishing transaction limits on the Card, charging fees to use such Cards, etc.).

5.2.8 The Card is subject to cancellation upon the following: Participant's death; Participant's termination of his or her participation in the HRA Plan; Employer's termination of participation in the Plan; Participant's failure to produce proper forms and supporting documentation required for substantiation of the expense paid with the Card; or if Participant breaches any of his or her obligations under the cardholder agreement.

5.3 Benefits Available in the Event of Death.

5.3.1 Standard HRA Survivor Benefit. For Plan Sponsor or Employer Plans that do not qualify for an Extended Survivor Benefit under Section 5.3.2, the following rules shall apply.If a Participant dies with a vested, positive account balance in any Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer), his or her surviving Spouse may file claims for Benefits incurred by the Participant and any Dependents until such account balance is exhausted. If a Participant dies without a surviving Spouse and with other Dependent(s), then the executor or administrator of the Participant's estate may file claims for any eligible expenses incurred by the Participant, and the Dependent(s) (or the guardian(s) of the Dependent(s)) may file claims for eligible Benefits on behalf of the Dependent(s) until such account balance is exhausted. If a vested, positive account balance remains in any Participant Account at a time when there are no surviving Dependents of the deceased Participant (including the surviving Spouse) or other survivors who may under applicable law be entitled to Benefits from a Participant Account, then the remaining balance in such Participant Account shall be applied in accordance with Section 4.10. The provisions of this section shall be administered pursuant to rules established by the Administrator.

5.3.2 Extended HRA Survivor Benefit. In the limited circumstances where an Employer or Plan Sponsor's Plan qualifies for an extended survivor benefit ("Extended Survivor Benefit"), the rules applicable to such Extended Survivor Benefit will be located

on the Employer and Participant online portal or upon request from the HRA Service Manager.

ARTICLE VI.
Additional Regulatory Provisions

6.1 Procedures for Claims, Internal Appeals, and External Review. The following provisions of this Section 6.1 set forth the minimum procedures for claims, internal appeals of Adverse Benefits Determinations, and external review of Final Internal Adverse Benefits Determinations required by law. These procedures shall be followed by the Administrator, its agents and subcontractors, and each Claimant under this Plan, and no judicial proceedings with respect to any request for Benefits hereunder may be commenced by any such Claimant until the procedures for claims and internal appeals of Adverse Benefits Determinations set forth herein have been followed and exhausted in full; provided, however, that any timeframe requirements or limitations applicable to the Plan or the Administrator may be voluntarily extended in writing by the Claimant in the Claimant's sole discretion; and any timeframe requirements or limitations applicable to the Claimant may be voluntarily extended in writing by the Administrator in the Administrator's sole discretion.

6.1.1 Claims. A person claiming Benefits under the Plan, which may include a Participant, Dependent, or any other covered individual as permitted by applicable law, or any such person's authorized representative (referred to in this section as the "Claimant"), shall deliver a request or claim for such Benefits in writing to the Plan. The Plan shall review the Claimant's request or claim for Benefits and shall thereafter notify the Claimant of its decision as follows:

6.1.1.1 The Plan shall provide the Claimant with written notice of its determination regarding the Claimant's request for Benefits not later than thirty (30) days after the date the Plan receives the Claimant's request for Benefits unless circumstances beyond the control of the Plan require an extension of time for reviewing such claim. In the event such circumstances require an extension of time for reviewing the Claimant's request for Benefits, the Plan shall, prior to the expiration of the initial thirty (30)-day period referred to above, provide the Claimant with written notice of the extension and of the circumstances that require such extension and of the date by which the Plan expects to render its determination. In no event shall such extension exceed a period of fifteen (15) days after the date of the expiration of the initial thirty (30)-day period, totaling forty-five (45) days at a maximum after the date the Plan receives the Claimant's request for Benefits (such thirty (30) or forty-five (45) day period being referred to herein as the "Initial Review Period").

6.1.1.2 If the Claimant's request for Benefits is approved by the Plan, the Plan shall notify the Claimant of such approval and proceed to process the request for Benefits.

6.1.1.3 In the event the Plan determines that additional information is required to review a claim, the Plan shall provide the Claimant with written notice of its need for additional information ("Notice of Incomplete Claim") as soon as practicable, but not later than the expiration of the applicable Initial Review period and the need for an extension of time to allow the Claimant sufficient time to gather and provide such additional information. The Notice of Incomplete Claim shall specifically describe the required information and provide the Claimant with at least forty-five (45) days after the date the Claimant receives such Notice of Incomplete Information (the "45-Day Response Period") to provide such additional information to the Plan. If the Claimant fails to respond with additional information before the expiration of the 45-Day Response Period, the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of the 45-Day Response Period, and the Notice of Incomplete Claim may include a provisional Adverse Benefits Determination that would take effect automatically under such circumstances. If, within the 45-Day Response Period, the Claimant provides additional information (whether or not such additional information is determined by the Plan to be sufficient to make a benefits determination), then the Plan shall provide the Claimant with written notice of its determination not later than fifteen (15) days after the date the Plan receives such additional information, regardless of whether either the Initial Review Period or the 45-Day Response Period will not yet expire prior to such fifteen (15) day period (such new review period shall be referred to herein as the "Incomplete Claim Review Period" and shall override the Initial Review Period under the circumstances described in this paragraph).

6.1.1.4 In the event of an Adverse Benefits Determination, the Plan shall provide written notice of such Adverse Benefits Determination and shall include in such notice, set forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant, the following:

(a) The specific reason or reasons for the Adverse Benefits Determination and sufficient information to identify the claim involved, if any, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to pertinent Plan provisions or IRS rules and regulations on which the Adverse Benefits Determination is based;

(c) An explanation of the Claimant's right to appeal such Adverse Benefits Determination and to have such appeal reviewed by someone other than (i) the original individual who made the initial Adverse Benefits Determination or (ii) such original individual's subordinate;

(d) A description of any additional material or information necessary for the Claimant to perfect the claim or appeal the Adverse

Benefits Determination and an explanation of why such material or information is necessary;

(e) An explanation of the Claimant's right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process;

(f) A description of available internal appeals procedures, including information regarding how to request a review of an Adverse Benefits Determination pursuant to Section 6.1.2 below and the timeframe within which to submit such a request;

(g) At no cost to the Claimant, copies of any additional evidence considered, relied upon, or generated by the Plan in connection with its review of the claim and an opportunity for the Claimant to respond to such additional evidence within the one hundred eighty (180)-day time period within which to appeal the Adverse Benefits Determination as described in Section 6.1.2.

(h) An explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

6.1.1.5 In the event that neither an approval of Benefits nor Adverse Benefits Determination is received or deemed received by the Claimant before the expiration of the Initial Review Period or the Incomplete Claim Review Period (whichever is applicable), the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of such applicable review period.

6.1.2 Health Care Debit Card Transactions are Not Claims. The presentation or use of a Card for payment at a merchant or vendor is not considered a submission of a formal claim under the Plan. In the event the merchant or vendor denies the transaction or the transaction is unable to be processed at the point of sale with that merchant or vendor, such denial of the transaction at the point of sale shall not be considered a denial under the Plan. If the transaction is approved at the point-of-sale, but the transaction is not electronically validated at the point of sale or later independently substantiated without further documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Third-party Administrator to verify that the amount was an eligible expense reimbursable by the Plan. Where the Third-party Administrator determines that an expense is not eligible to be paid with the Card because the Participant or Dependent has not submitted the information requested by the Third-party Administrator to substantiate the claim as an expense reimbursable under the Plan (*e.g.*, where the Card is suspended, the Plan requests reimbursement of the unsubstantiated expense and/or the Plan applies an overpayment against the applicable Participant Account

and offsets against future claims), then denial of such Card payment would become a denial subject to the formal claims and appeals procedures under this Section.

6.1.3 Internal Appeals of Adverse Benefits Determinations.

6.1.3.1 In the event an Adverse Benefits Determination has been received or deemed received by a Claimant, the Claimant may appeal such Adverse Benefits Determination by submitting to the Plan a written request for a review of such Adverse Benefits Determination. Any such written request for review must be delivered to the Plan not later than one hundred eighty (180) days after the date the Claimant receives written notification of the Adverse Benefits Determination or from the date the Claimant was deemed to have received an Adverse Benefits Determination for such claim.

6.1.3.2 During the period prescribed in paragraph 6.1.3.1 for filing a request for review of an Adverse Benefits Determination, the Plan shall permit the Claimant to review the claim file and other pertinent documents and submit written issues and comments concerning the Claimant's claim.

6.1.3.3 Upon receiving a request by a Claimant for a review of an Adverse Benefits Determination, the Administrator, or one or more representatives designated by the Administrator, shall review such Adverse Benefits Determination promptly, and shall provide written notice to the Claimant of its determination within sixty (60) days after the date on which the Plan received the request for review of such Adverse Benefits Determination.

6.1.3.4 If the Claimant's request for Benefits is approved by the Plan upon review of the Adverse Benefits Determination, the Plan shall notify the Claimant of such approval and proceed to process the request for Benefits.

6.1.3.5 If in connection with its review of an Adverse Benefits Determination, the Administrator or its designees considered, relied upon, or generated any new or additional evidence or rationale for a Final Internal Adverse Benefits Determination, the Plan shall, as soon as practicable but not later than thirty (30) days after the date the Plan receives the Claimant's request for review of such Adverse Benefits Determination, provide the Claimant with written notice of such new evidence or rationale ("Notice of New Information") and the opportunity for the Claimant to provide a written response to such new evidence or rationale not later than fifteen (15) days after date the Claimant receives such Notice of New Information (the "15-Day Response Period"). If the Claimant fails to provide a written response before the expiration of the 15-Day Response Period, the claim shall be deemed to have received an Final Internal Adverse Benefits Determination as of the day immediately following the expiration of the 15-Day Response Period, and the Notice of New Information may include a provisional Final Internal Adverse Benefits Determination that would take effect automatically under such circumstances. If within the 15-Day Response Period, the Claimant provides a

written response to such new evidence or rationale, then the Administrator or its designees shall review such new evidence or rationale and the Plan shall provide the Claimant with written notice of its determination not later than (i) fifteen (15) days from the date of the Plan's receipt of such written response or (ii) sixty (60) days from the date on which the Plan received the request for review of such Adverse Benefits Determination, whichever occurs first.

6.1.3.6 The Plan shall provide written notice to the Claimant of a Final Internal Adverse Benefits Determination and shall include in such notice, set forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant the following;

(a) The specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to the pertinent Plan provisions or IRS rules and regulations on which the Final Internal Benefits Determination is based.

(c) A description of available external review procedures, including information regarding how to request an external review of the Final Internal Adverse Benefits Determination pursuant to Section 6.1.4 below and the timeframe within which to submit such a request; and

(d) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist Claimants with the external review procedures.

6.1.3.7 In the event that neither an approval of Benefits nor a Final Internal Adverse Benefits Determination is received or deemed received by the Claimant within sixty (60) days after the date the Plan receives the written request for review of the Adverse Benefits Determination, the claim shall be deemed to have received a Final Internal Adverse Benefits Determination as of the sixty-first (61st) day following the date Plan received the written request for review of the Adverse Benefits Determination.

6.1.4. External Review of Final Internal Adverse Benefits Determinations.

6.1.4.1 After receipt or deemed receipt of a Final Internal Adverse Benefits Determination, a Claimant may file a written request for an external review of such Final Internal Adverse Benefits Determination. Any such request for review must be delivered to the Plan not later than the first day of the fifth month following the date the Claimant receives or is deemed to receive a Final Internal

Adverse Benefits Determination. If such request for external review deadline falls on a Saturday, Sunday, or other non-business day, then the request for external review must be delivered to the Plan not later than the next calendar day that is not a Saturday, Sunday, or other non-business day (the "Initial External Review Filing Deadline").

6.1.4.2 Within five (5) business days after receiving the external review request, the Plan must complete a preliminary review to determine if:

(a) the Claimant was covered under the Plan,

(b) the Claimant provided all the information and forms necessary to process the external review,

(c) the Claimant has followed and exhausted the internal appeals procedures, and

(d) the Final Internal Adverse Benefits Determination related to the failure of the Claimant to meet eligibility requirements under the Plan, as Final Internal Adverse Benefits Determinations based upon a failure to meet eligibility requirements are not subject to external review.

6.1.4.3 Within one (1) business day after completion of its preliminary review, the Plan shall provide written notice to the Claimant of the outcome of its review. If the Claimant's request for external review is complete but the Final Internal Adverse Benefits Determination is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If the Claimant's request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and the Claimant shall be permitted to complete the request not later than the Initial External Review Filing Deadline or forty-eight (48) hours after the Claimant's receipt of the preliminary review notice, whichever is later.

6.1.4.4 If the Plan receives a timely, completed request for external review of a Final Internal Adverse Benefits Determination that is eligible for review in accordance with the requirements of this Section 6.1.3, the Plan shall assign an Independent Review Organization (IRO) to review the claim, using a method of assignment that assures the independence and impartiality of the assignment process. The IRO shall be required to provide written notice to the Claimant stating that:

(a) The Claimant's request is eligible for external review and has been assigned to such IRO;

(b) The Claimant has the right to submit additional information in writing to the IRO within ten (10) business days after the date the Claimant receives such notice and, if the IRO receives such additional information within ten (10) business days after the Claimant receives such notice, then (i) the IRO must consider such additional information in its external review, and (ii) the IRO is required to forward such additional information submitted by the Claimant to the Plan within one (1) business day after the date the IRO receives such information;

6.1.4.5 Within five (5) business days after the date the IRO receives the external review assignment, the Plan is required to provide the IRO with all documents and information considered by the Plan in making its Adverse Benefits Determination and Final Internal Adverse Benefits Determination;

6.1.4.6 Upon receiving from the IRO any additional information submitted by the Claimant, the Plan may reconsider the Final Internal Adverse Benefits Determination. If the Plan reverses the Final Internal Adverse Benefits Determination upon such review, it must notify the Claimant and the IRO within one (1) business day after making such reversal, and the IRO must terminate its external review;

6.1.4.7 The IRO is not bound by the prior Adverse Benefits Determination or Final Internal Adverse Benefits Determination of the Plan in making its external review decision.

6.1.4.8 Within forty-five (45) days after the IRO receives the external review request, the IRO must provide written notice of the final external review decision to the Claimant and the Plan. Such notice shall include the following information:

(a) A general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial;

(b) The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision;

(c) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;

(e) A statement that the IRO's decision is binding unless other remedies are available to the Plan or the Claimant under state or federal law;

(f) A statement that judicial review may be available to the Claimant; and

(g) A phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

6.1.4.9 An external review decision by the IRO upholding the Plan's Final Internal Adverse Benefits Determination is binding on the Claimant but does not prohibit the Claimant from subsequently pursuing other remedies available under state or federal law. If the IRO reverses the Plan's Final Internal Adverse Benefits Determination, the Plan is required by law to provide reimbursement for the claim without delay; provided, however, that the Plan shall still be entitled to subsequently pursue other legal remedies that may be available under state or federal law.

6.2 Protected Health Information. The Plan 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).

6.2.1 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:

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

6.2.1.2 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;

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

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

6.2.1.5 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;

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

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

6.2.2 Plan Sponsor and Employer Uses of Protected Health Information.

6.2.2.1 HIPAA Plan Amendment. Members of the workforce of an Employer or Plan Sponsor may have access to the individually identifiable health information of Participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer or Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. The provisions of Section 6.2.2 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 or Plan Sponsor'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.

An Employer or Plan Sponsor 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.

6.2.2.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to an Employer or Plan Sponsor 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, employee ID or social security number, contribution history, account balance information, age, employment status (active, retired, separated), limited account status, 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 each Employer and Plan Sponsor acknowledge and agree that enrollment and disenrollment information is information of the Employer or Plan Sponsor and is held on behalf of the Employer or Plan Sponsor by the Plan. Enrollment and disenrollment information held at any time by the Employer or Plan Sponsor is held in its capacity as an Employer or Plan Sponsor and is not PHI.

6.2.2.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to an Employer or Plan Sponsor, provided that the Employer or Plan Sponsor 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.

"*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 or Employer has provided health benefits under the Plan; and (2) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.2.2.4 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 Section 6.2.2.5 and obtaining written certification pursuant to Section 6.2.2.8, the Plan may disclose PHI and Electronic PHI to an Employer or Plan Sponsor, provided that the Employer or Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.2.2.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer or Plan Sponsor 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 or Plan Sponsor in connection with any other benefit or benefit plan of the Employer or Plan Sponsor or any employment-related actions or decisions.

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

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

6.2.2.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer and the Plan Sponsor agree that with respect to any PHI it receives from the Plan pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.2.2.8 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), such Employer and the Plan Sponsor shall:

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

6.2.2.5.2 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 and the Plan Sponsor with respect to PHI;

6.2.2.5.3 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 or Plan Sponsor;

6.2.2.5.4 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;

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

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

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

6.2.2.5.8 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;

6.2.2.5.9 if feasible, return or destroy all PHI received from the Plan that the Employer or Plan Sponsor 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

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

6.2.2.6 Additional Requirements. Each Employer and the Plan Sponsor further agree 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 Section 6.2.2.8 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 or Plan Sponsor who need the information for Plan Administration Purposes and employees of the Employer or Plan Sponsor who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer or Plan Sponsor, 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 or Plan Sponsor 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 or Plan Sponsor 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.

6.2.2.7 Adequate Separation Between Plan and Employer and Between Employees Who Perform Plan Administration Functions and Employees Who Do Not Have Plan Administration Functions. Any Employer or Plan Sponsor that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.2.2.8 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 or Plan Sponsor'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 or Plan Sponsor 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 or Plan Sponsor for non-compliance pursuant to the Employer's or Plan Sponsor's employee discipline and termination procedures.

The Employer and Plan Sponsor 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.

6.2.2.8 Certification of the Plan Sponsor and Employers. 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 an Employer or Plan Sponsor only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer or Plan Sponsor acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer or Plan Sponsor agrees to the conditions of disclosure set forth in Section 6.2.2 and all other conditions and requirements of this HIPAA Plan Amendment.

6.3 Qualified Medical Child Support Orders and National Medical Support Notices. The Plan shall comply with all applicable rules and laws relating to Qualified Medical Child Support Orders ("QMCSO") and National Medical Support Notices ("NMSN"). In the event a QMCSO or NMSN is received by the Plan, the Plan will follow the policies and procedures for determining and administering such order or notice as the same may be adopted or revised from time to time by the Administrator.

ARTICLE VII.
Administrator

7.1 Rights and Duties. By execution of the Plan Adoption Agreement, the Plan Sponsor authorizes the Administrator to administer the Plan in accordance with its terms and all rules, policies and procedures established by the Plan as are necessary and appropriate for the administration of the Plan. The delegation of administrative authority to the Administrator shall include the following responsibilities and authority, which the Administrator shall exercise in a uniform manner so that all persons similarly-situated shall be similarly treated:

7.1.1 To determine entitlement to Benefits to the extent set forth under Articles V and VI.

7.1.2 To compute the amount and kind of Benefits payable to or with respect to Participants.

7.1.3 To maintain all the necessary records for the administration of this Plan other than those maintained by the Plan Sponsor or a Participating Employer.

7.1.4 To prepare and file or distribute all reports and notices required by law with respect to the Plan.

7.1.5 To authorize all disbursements from the Plan.

7.1.6 To direct the allocation, investment, reallocation, and redemption of funds within Participant Accounts and Employer Accounts.

7.1.7 To act on behalf of the Plan Sponsor as permitted or required by the Plan, the Plan Adoption Agreement, or as otherwise directed by the Plan Sponsor.

7.1.8 To interpret provisions and the Plan Documents for purposes of administration of the Plan.

7.1.9 To establish or approve such rules, policies and procedures for the funding and administration of this Plan that are not inconsistent with the terms of the Plan Documents.

7.2 Information. To enable the Administrator to perform its functions, the Plan Sponsor and Employer shall supply the Administrator and other Plan Representatives with full and

timely information on all matters relating to contributions and each Employee's eligibility to participate in the Plan. The Administrator shall maintain such information and advise the Employer or Plan Sponsor of such other information as may be necessary to the administration of the Plan. The Administrator and other Plan Representatives shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action of the Employer for the purpose of performing its duties under the Plan, and the Administrator and other Plan Representatives shall have the right to rely on information provided by the Employer or Plan Sponsor with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action of the Employer.

7.2.1 Within a reasonable amount of time after receipt of a complete Enrollment File with respect to a Participant, the Plan shall deliver a written acknowledgement to the Participant, acknowledging establishment of the Participant Account or Accounts and confirmation of any contributions received. The information will also include a Summary Plan Description. At the time an Employee becomes Claims-Eligible, the Plan shall provide the Participant with information relating to his or her Participant Account or Accounts and how to request payment of Benefits.

7.2.2 The Plan shall provide to Participants a published statement at regular intervals which shall include the following information: name and address; contributions received and the month the amount was posted to the Participant Account or Accounts; total Participant Account value at statement date; income earned or other gain or loss; all payout and disbursement amounts, and increases or decreases for expenses or benefit payments; ending/forward balance; and contact information for error corrections or questions regarding the statement.

7.3 **Delegation of Certain Non-discretionary Duties.** In accordance with the terms of the Plan Adoption Agreement, the Plan Sponsor or its designee shall serve as the Administrator for the Plan. Without relieving the Administrator of any of its obligations under the Plan, the Plan Sponsor has engaged the HRA Service Manager to provide ministerial and non-discretionary Plan Administration Support Services as specified herein and in the other Plan Documents or otherwise at the direction of the Plan Sponsor or Administrator. The Plan Sponsor has authorized and directed the HRA Service Manager to assist the Administrator in the performance and execution all of the duties, powers, and responsibilities of the Administrator specifically defined in the Plan Documents, subject to the approval and direction of the Administrator for any such duties, powers, or responsibilities that require the discretion of the Administrator or that are not otherwise specifically prescribed in the Plan Documents, such assistance to include without limitation the specific non-discretionary and ministerial Plan Administration Support Services. Where the Plan Documents or Plan Sponsor specifically direct or authorize the HRA Service Manager to perform a certain function, task, service, or role on behalf of the Plan Administrator, such actions of the HRA Service Manager in fulfilling those obligations shall not be considered discretionary decisions of the HRA Service Manager. Without relieving the HRA Service Manager of its obligations under the Plan Documents, the Plan Sponsor has authorized the HRA Service Manager to designate one or more Plan Representatives as agents or sub-contractors of the HRA Service Manager to carry out any administrative services to be performed by the HRA Service Manager,

including one or more third-party service providers for record-keeping, regulatory reporting, customer service, claims and contribution processing services, creation or production of Plan forms, notices, and literature, investment management services, and a custodian/transfer agent to hold the assets of the Plan

7.4 **Compensation of Administrator and Plan Expenses.** The Plan Sponsor agrees that the Administrator shall be entitled to compensation as agreed between the Plan Sponsor and the Administrator. The Plan Sponsor also agrees that the HRA Service Manager shall be entitled to compensation payable from Plan assets at the rate of compensation provided for in the Plan Adoption Agreement. The Plan Sponsor hereby authorizes the Administrator (and the HRA Service Manager to the extent it is delegated non-discretionary and ministerial duties and responsibilities of the Administrator) to employ such consultants, investment managers, administrators, lawyers, accountants, agents, actuaries and other service providers as it reasonably deems necessary or appropriate in carrying out its responsibilities under the Plan Documents, i as provided in the Plan Adoption Agreement, and such service providers shall be entitled to reasonable compensation for and reimbursement of expenses relating to such services which may be paid by assessments from Participant Accounts as set forth in the Plan Documents or as otherwise required or permitted by applicable law or mutually determined by the Plan Sponsor and the HRA Service Manager. Additionally, all other reasonable expenses of administration of the Plan, including but not limited to fees and expenses for: legal, benefits staff, third-party administrator, auditing, printing, postage, mail service, plan administration software or technology, bank, trustee, custodian, consultant, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Plan, Participants, the Plan Sponsor, or a Participating Employer may be paid through reasonable fees and assessments from Participant Accounts from time to time, or by the Employer.

7.5 **Resignation and Removal of, and Successors to Administrator, HRA Service Manager, and Other Plan Representatives.** Resignation, removal, and replacement of the Administrator shall be determined according to any rules, policies, procedures, or contractual arrangements between the Plan Sponsor and the Administrator. Resignation, removal, or replacement of the Administrator shall not affect the duties and responsibilities or role of the HRA Service Manager or other Plan Representatives set forth in the HealthInvest HRA Plan Documents. Resignation, removal, and replacement of the HRA Service Manager or other Plan Representatives shall be governed by Sections 7.5.2 and 7.5.3 hereof. If for any reason a vacancy should occur in the position of the Administrator, the Plan Sponsor may appoint a successor Administrator or succeed as the Administrator until such time as a successor Administrator is appointed by the Plan Sponsor. Unless otherwise agreed by any Administrator, no successor or predecessor Administrator shall be liable for the acts or ommissions of any other Administrator.

7.6 **Discretion and Standard of Review**. The Administrator has full and absolute discretion in the exercise or delegation of each and every aspect of the rights, power, authority and duties relating to the administration of the Plan, including without limitation, the authority to determine all facts, to interpret this Plan, to apply the terms of this Plan to the facts determined, to make decisions based upon those facts and to make any and all other decisions required of it by this Plan, such as the right to Benefits, the correct amount and form of Benefits, the determination of any appeal, the review and correction of the actions of any Plan Representative, and the other

rights, powers, authority and duties specified in this paragraph and elsewhere in this Plan. Notwithstanding any provision of law, or any explicit or implicit provision of this document, any action taken, or finding, interpretation, ruling or decision made by the Administrator in the exercise of any of such rights, powers, authority or duties under this Plan shall be final and conclusive as to all parties, including without limitation all Participants, former Participants and Dependents, or any other person entitled to receive Benefits from a Participant Account, regardless of whether the Administrator (or one or more of the members of any Plan administrative committee) may have an actual or potential conflict of interest with respect to the subject matter of the action, finding, interpretation, ruling or decision. No such final action, finding, interpretation, ruling or decision of the Administrator shall be subject to *de novo* review in any judicial proceeding. No such final action, finding, interpretation, ruling or decision of the Administrator may be set aside unless it is held to have been arbitrary and capricious by a final judgment of a court having jurisdiction with respect to the issue.

ARTICLE VIII.
Amendment and Termination

8.1 Amendments.

8.1.1 Subject to the provisions of the Plan Adoption Agreement and the following paragraphs of this Section 8.1 and Section 8.2 hereof, the Plan Sponsor shall have the right to amend the Plan from time to time, including amendments to its elections under the Plan Adoption Agreement.

8.1.2 Any Plan amendment proposed by the Plan Sponsor must be submitted to the HRA Service Manager, and such amendment shall not take effect until the HRA Service Manager delivers written acceptance of such amendment, subject to the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the Plan Adoption Agreement.

8.1.3 Subject to Section 8.1.4 hereof and the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the Plan Adoption Agreement and except as otherwise provided in the Plan Adoption Agreement, the HRA Service Manager shall have the right to amend the provisions of the HealthInvest HRAPlan Coverage Documents from time to time, and to amend or cancel any such amendments to the extent specifically authorized and directed by the Plan Sponsor in the Plan Adoption Agreement. The HRA Service Manager shall deliver to the Plan Sponsor and/or the Administrator notice of any amendment within ninety (90) days after the effective date of such amendment. Notwithstanding the stated effective date of any amendment, such amendment may be current, retroactive, or prospective, in each case as provided therein. If the Plan Sponsor does not submit any objections or proposed amendment to the HRA Service Manager's revisions within thirty (30) days of receipt by the Plan Sponsor and/or Administrator, such revisions are deemed approved by the Plan Sponsor and/or Administrator.

8.1.4 Unless otherwise provided in the Plan Adoption Agreement or applicable Trust Agreement, no amendment to the Plan shall permit any part of the Plan assets, to be used for or diverted to purposes other than for the payment of Benefits under the Plan to Participants, Dependents, and any other person entitled to receive Benefits from a Participant Account and to defray reasonable expenses of administering the Plan, and no amendment may permit amounts credited to a Participant Account to be used to provide Benefits to a person other than the Participant, his or her Dependents, or any other person specifically entitled to receive Benefits from such Participant Account, unless there has been a forfeiture of the balance of such Participant Account.

8.1.5 Any amendment to the Plan required by applicable law shall take effect as required by such applicable law to the extent such requirements are inconsistent with this section.

8.2 Termination/Discontinuance of Contributions/Transfers. No provision of the Plan shall impose any obligation on the Employer or Plan Sponsor to make, or continue making, contributions to the Plan, and, except as it may otherwise be legally obligated, the Employer or Plan Sponsor may discontinue Plan contributions at any time. Except as otherwise provided in the Plan Adoption Agreement, in the event of such a discontinuance of contributions, Plan assets shall continue to be used to provide Benefits in accordance with the terms of the Plan, and any remaining Plan assets will be returned to the Employer or Plan Sponsor upon the satisfaction of all liabilities to provide Benefits under the Plan. Notwithstanding the foregoing, the Plan Sponsor may terminate the Plan, or partially terminate the Plan with respect to any class of Participants, or cause all or an allocable portion of the Plan assets to be transferred to another administration services provider or welfare benefit fund for the benefit of such Participants, provided that: (a) any such transfer does not violate the terms of the Trust Agreement, applicable law, or any legal obligation that the Plan Sponsor or Employer has outside of the terms of the Plan; (b) the Plan Sponsor has provided the HRA Service Manager with a least ninety (90) days' prior notice of such transfer or such shorter time period agreed to in writing by the HRA Service Manager; and (c) the Plan Sponsor has agreed to indemnify and hold harmless the HRA Service Manager and its agents, subcontractors, officers, representatives, and employees from any liability associated with such transfer of assets, and to provide such other consideration to the HRA Service Manager in connection with the transfer as provided for under the Plan Adoption Agreement.

ARTICLE IX.
Miscellaneous

9.1 Applicable Law. This Plan shall be construed, administered, and governed under the laws of the domicile of the Plan Sponsor and the applicable federal laws of the United States of America, such federal laws to preempt state law to the extent permitted by applicable state and federal law. If any provision of this Plan shall become or be held to be illegal, invalid, or unenforceable for any reason, such illegality or invalidity shall not affect the remaining portions of this Plan, which shall remain in full force and effect, unless such illegality or invalidity prevents accomplishment of the objectives and purposes of the Plan. In the event of any such holding, the

HRA Service Manager may immediately, and if in accordance with law, retroactively, amend the Plan as is necessary to remedy such defect.

APPENDIX A
To Plan Document

Definitions

"Administrator" means the Plan Sponsor or such other person or persons designated in writing as the Administrator in the Plan Adoption Agreement. Some or all of the responsibilities of the Administrator may be carried out by one or more third parties (including the HRA Service Manager or one or more other third-parties to provide enrollment, remittance, claims-adjudication, trustee, custodial, regulatory reporting, and/or record-keeping services) engaged by the Plan Sponsor or the Administrator under the Plan Adoption Agreement or under other trust document or other separate contracts; provided that, such the engagement by the Plan Sponsor of the Administrator, and the engagement by the Plan Sponsor or the Administrator of third-party service providers is not intended to transfer fiduciary responsibility or liability to any person.

"Adverse Benefits Determination" means any denial of a request for Benefits or any rescission or termination of Benefits, in each case in whole or in part, all as more specifically described in the Department of Labor regulations, specifically, 29 C.F.R. §2560.503-7(m)(4). A transaction paid for to a merchant or vendor with the Plan's Health Care Debit Card shall not be considered an Adverse Benefits Determination until such time the Participant receives a communication or notice from the Plan that the transaction is not a Qualified Health Care Expense.

"Benefit Payment Period" means the accounting period for payment to Participants of Benefits that have been approved pursuant to Plan policies and procedures.

"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.

"Card" means the debit/credit card(s) provided by the Administrator and used by Participants for the payment of Benefits under the Plan.

"Card Program" means the procedure and system established by the Administrator utilizing Cards for the payment of Benefits.

"Claimant" has the meaning ascribed to such term in paragraph 6.1.1 hereof.

"Claims Eligibility Date" means, with respect to any Participant Account, the date on or after the Participant Eligibility Date on which a Participant becomes eligible to file claims for expenses incurred on or after such date; provided that reimbursement for any such claims shall be (i) subject to the Plan having first received a complete Enrollment File for such Participant and (ii) limited to the extent that there is a positive account balance in such Participant Account. The Claims Eligibility Date for each account type is specified in the Plan Adoption Agreement.

"Claims-Eligible" means, with respect to one or more Participant Accounts or one or more types of coverage under the Plan, that a Participant has become eligible to file claims for Qualified Health Care Expenses or Excepted Benefits, as applicable, under the Plan Document governing the eligibility for such Plan coverage under such Participant Account or Accounts.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations promulgated thereunder, as amended from time to time.

"Credited" means, with respect to the timing of a contribution made to a Participant Account, the date on which the Participant who received such contribution earned or became entitled to such contribution pursuant to the terms of this Plan, applicable collective bargaining agreements, Employer policies, or other or other contractual or legal obligations of the Employer.

"Dependent" means a Participant's spouse, dependent (as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), or child (who as of the end of the taxable year has not attained age 27) as determined under IRC §105(b).

"Employee" means any individual that the Employer determines is, or classifies as, a current or former employee of the Employer, including any such person covered by a collective bargaining agreement providing for coverage in the Plan, or otherwise based upon the Employer policies or other contractual or legal obligations of the Employer.

"Employer" with respect to any Participant, means the Plan Sponsor (for a single-employer plan) or the Participating Employer (for a multi- or multiple-employer plan) who made or is making contributions on to the HealthInvest HRA Plan on behalf of the Participant.

"Employer Account" refers to an account for the Employer to account for contributions and other Plan assets not allocated to Participant Accounts.

"Employer Participation Agreement" means a Participation Agreement executed by a Participating Employer, pursuant to which the Participating Employer agrees to adopt and participate in the Plan, accepts the terms and conditions of the Plan Adoption Agreement and the the other HealthInvest HRA Plan Documents, and provides information unique to the Participating Employer for the administration of its Plan.

"Enrollment File" means the paper enrollment form, online enrollment information, or enrollment file provided by the Plan Sponsor, Employer or Participant with the information required by the Administrator in order to enroll a Participant in the Plan.

"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)(i)-(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.

"Final Internal Adverse Benefits Determination" means an Adverse Benefits Determination that has been upheld by the Plan at the completion of the internal appeals procedures set forth in Section 6.1.2.

"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) as such term "group health plan" is defined under IRC §§9832(a) and 5000(b)(1) and Treasury Regulation §54.9831-1(a)(1). For purposes of plans subject to ERISA, group health plan shall also have the meaning ascribed under ERISA §3(1) for an employee welfare benefit plan.

"In-service Benefits" means the Benefits and coverage provided under the HealthInvest HRA Plan while a Participant is currently employed by the Employer. The terms and conditions of In-Service Benefits is governed by a separate Plan Document for In-service Benefits Coverage.

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

"IRS" means the Internal Revenue Service.

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

(i) For 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);

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

(iv) For eligibility for limited coverage prior to separation for Participants with Post-separation Accounts (as permitted by the Plan Sponsor's or Employer's plan design elections); and

(v) For eligibility for limited coverage for Dependents who are not integrated with an employer-sponsored group health plan at the time a Qualified Health Care Expense is incurred.

Limited HRA Coverage will be limited to Excepted Benefits only for purposes described in clauses (iii)-(v), 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, and pursuant to the terms and conditions of this Plan Document for Limited HRA Coverage.

"Mandates" means provisions of PPACA known as the "PHSA 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).

"Master Trust" means the master trust created under that certain Declaration of Trust Establishing the HealthInvest HRA Master Trust, effective as of September 1, 2017, established by Washington Trust Bank, as the Master Trustee, as amended, restated, or replaced from time to time.

"Master Trust Adoption Agreement" means that certain Master Trust Adoption Agreement attached as an Addendum to the Plan Adoption Agreement of the Plan Sponsor, among the Master Trustee, the HRA Service Manager, the Plan Sponsor, and the Participating Trust Signatory.

"Master Trustee" means the nondiscretionary, directed trustee, and custodian under the Master Trust.

"Participant" means a current or former Employee who has become a Participant as described in Article II, and whose status as a Participant remains active pursuant to Section 2.2 with respect to at least one Participant Account. However, a Participant shall only become Claims-Eligible as described in Section 2.1.

"Participant Account" refers to any account maintained with respect to a Participant to record contributions and adjustments relating thereto and established for the purpose of the payment of Benefits.

"Participant Eligibility Date" unless otherwise specified in writing by the Employer or Plan Sponsor, is the date on which a contribution or an Enrollment File is received by the Plan for a current or former Employee. The Participant Eligibility Date for any Employee may not be earlier than the Plan Effective Date; provided that, for Participants whose plan assets have been transferred by the Plan Sponsor or the Employer from another plan, the Participant Eligibility Date may coincide with each Participant's eligibility date under the prior plan, if designated in writing

by the Plan Sponsor or Employer.

"Participating Employer" shall mean a "Participating Employer" named pursuant to an Employer Participation Agreement. References to the term "Participating Employer" used herein shall apply only with respect to multi- or multiple-employer plans. For single-employer plans, provisions applicable to Participating Employers shall have no application.

"Participating Trust" is defined in the Master Trust Adoption Agreement.

"PHI" (or "Protected Health Information") is defined in Section 6.2.2.1.

"Plan Administration Support Services" provided by the HRA Service Manager or any subcontractor of the HRA Service Manager shall include non-discretionary assistance and support for the Administrator in the performance of all duties, powers, and responsibilities of the Administrator specifically set forth in the Plan Documents, policies, or procedures, and other Plan forms and materials (as the same may be amended from time to time) and other non-discretionary duties, powers, and responsibilities approved or directed by the Plan Sponsor from time to time, including without limitation the administration support services described in Appendix B hereof.

"Plan Adoption Agreement" means a Plan Adoption Agreement executed by the Plan Sponsor and accepted by the HRA Service Manager, as the same may be amended, restated, or replaced from time to time, pursuant to which the Plan Sponsor establishes the Plan, identifies the Particpating Employers and Employees eligible to participate in the Plan, and specifies other terms and conditions for the provision of Benefits and administration of the Plan. The terms and provisions of the Plan Adoption Agreement, contributions and disbursements pursuant thereto, and any changes thereto, are all subject to the rules, policies and procedures set forth in the Plan Documents or in Plan forms, policies, and procedures approved by the Plan Sponsor and the HRA Service Manager prior to adoption of the Plan, or as otherwise approved or established by the Administrator pursuant to the direction and authorization of the Employer in the Plan Adoption Agreement. With respect to any Participating Employer, the term "Plan Adoption Agreement" shall include the Employer Participation Agreement of the Employer, which by its terms incorporates the terms of and becomes a part of the Plan Adoption Agreement for purposes of the Participating Employer's Plan.

"Plan Coverage Document" shall mean this Plan Coverage Document and any other plan coverage document governing the terms and conditions of various types of HRA plan coverage included in the HealthInvest HRA Plan.

"Plan Document or HealthInvest HRA Plan" is defined in Section 1.2.

"Plan Effective Date" for this Plan shall have the meaning set forth for such term or the term "Plan Effective Date" in the Plan Adoption Agreement, notwithstanding that the Plan and

Plan Documents may be amended, restated, or replaced from time to time.

"Plan Representative" shall mean any service provider or other third party appointed by the Plan Sponsor or Administrator to perform services or otherwise act on behalf of the Administrator, including the HRA Service Manager, and any trustee, custodian, or investment manager and any subcontractor of any of the above as permitted under the Plan Documents.

"Plan Sponsor" shall be the "Plan Sponsor" named in the Plan Adoption Agreement.

"Plan Year" shall, for regulatory reporting purposes, coincide with a regular calendar year. The first Plan Year (which may be a partial Plan Year) is the period from the Effective Date through last date of the Plan Year that includes the Effective Date.

"Post-separation Benefits" means the Benefits and coverage provided under the HealthInvest HRA Plan after a Participant is retired or otherwise separated from service from the Employer. The terms and conditions of Post-separation Benefits is governed by a separate Plan Document for Post-separation Benefits Coverage.

"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.

"Premium Reimbursements" means premium reimbursements for out-of-pocket, after-tax payments made to insurance companies, health maintenance organizations, health plans, preferred provider organizations, qualified long-term care insurers, any part of Medicare, or to the Employer for COBRA premium payments.

"Protected Health Information" is defined under the term "PHI."

"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 who last made or caused contributions to be made into such Participant's Participant Account, that such Participant has become re-employed with such Employer (whether or not such re-employment is on a full-time, part-time, or temporary basis) under circumstances that would constitute a traditional employment relationship under customary employment standards and policies. Whether or not a Participant is "Re-employed" for purposes of Claims-Eligibility shall be subject to applicable law and rules, policies and procedures of the Employer.

"Spouse" means, with respect to any Participant, the person to whom the Participant is legally married under any jurisdiction or the person with whom the Participant has otherwise met

the legal requirements to establish a domestic partnership if the Participant resides in a jurisdiction where the legal status of a domestic partnership is the same as that of a legal spouse.

"Summary Plan Description" means a written document that (1) summarizes the terms and conditions of the Plan, (2) informs participants, dependents, and other beneficiaries of Plan of their rights, benefits, and responsibilities under and with respect to the Plan, and (3) includes other information that is determined by the Administrator to be important, informational, or required by applicable law.

"Trust" means, if a trust is established at the election of the Plan Sponsor, any such trust established pursuant to the Trust Agreement and that becomes a Participating Trust as defined under the Master Trust. "Trust Agreement" means the Trust agreement or other trust document attached to the Plan Adoption Agreement into which assets for the Plan are funded and held through the custodial account established by the Plan Sponsor under the Plan Adoption Agreement.

"Trust Agreement" means the Plan Sponsor Trust agreement or other trust document attached to the Plan Adoption Agreement into which assets for the Plan are funded and held through the custodial account established by the Plan Sponsor under the Plan Adoption Agreement and that becomes a Participating Trust as defined under the Master Trust.

"Valuation Period" means the period for determining investment values for Accounts and shall be no less frequently than monthly.

"Wrap Document(s)" means any written plan document, summary plan description, summary of material modification, or other controlling document, as applicable, of the Plan Sponsor that is intended to wrap around and integrate this HealthInvest HRA Plan, for purposes of outlining Plan eligibility or other rules, and that is incorporated herein as a governing Plan Document for purposes of administering and adopting the HealthInvest HRA, as the same may be amended from time to time.

APPENDIX B
To Plan Document

Plan Administration Support Services

Plan administration support services that may be provided by the HRA Service Manager or any subcontractor of the HRA Service Manager shall include non-discretionary assistance and support for the Administrator in the performance of all duties, powers, and responsibilities of the Administrator specifically set forth in the Plan Documents, policies, or procedures, and other Plan forms and materials and other non-discretionary duties powers, and responsibilities approved by the Plan Sponsor from time to time, including without limitation the following administration support services:

1. Provide assistance to Plan Sponsor and Participating Employers with Plan design elections and completion of plan adoption documents.
2. Provide Plan Sponsor and Participating Employers with Plan adoption/welcome package after receipt of a completed adoption agreement in good order.
3. Design and print Plan literature (including, but not limited to, enrollment forms, claim forms, Investment allocation forms, question-and-answer forms, Plan Summary/Summary Plan Description, etc.).
4. Maintain an inventory of necessary forms and literature
5. Draft, create, and make any changes to Plan documents, Plan forms, Plan materials, Plan literature, and Plan policies and procedures as are routine, desirable, or necessary to improve the efficiency and effectiveness of the operation of the Plan, clarify ambiguities for the benefit of the Administrator, Plan Sponsor, or Eligible Participants, and to comply with applicable legal requirements.
6. Assist with communication between, and coordinate the activities of, all subcontractors and service providers to the Plan.
7. Facilitate payment of operating expenses of the Plan in accordance with the Plan Documents and direction of the Administrator.
8. Provide reasonable assistance and services necessary to obtain or make all necessary regulatory or other governmental filings, registrations and approvals for this Plan, including providing the following information and reports to the Plan Sponsor and Participating Employers:

    - Quarterly fund activity summary – Covers contributions, Investment earnings, and distributions for all participating employees on an aggregate basis;
    - Quarterly and annual trust statements – Includes balance sheets, as well as income and expense statements;

- Disbursement Report – Quarterly report containing aggregate claims paid by category: medical, dental, vision, prescriptions and premiums;
- Other reports – The third-party administration service provider will provide other reports that are reasonable and customary, including transaction reports confirming contributions.

9. Maintain and provide access to all records of the custodian, the HRA Service Manager and others relative to the Plan as needed for Plan and Trust audits.
10. Provide recordkeeping services for Participant and Employer Accounts.
11. Provide ministerial claims reimbursement services to Participants and Employers (for Employer Accounts). Claims reimbursement services include determination if a receipt is valid and covers a qualified expense under IRC §213(d), and delivery of all applicable notices required in the Plan document. Any determination on appeal requiring discretion must be approved in writing by the Administrator.
12. Provide customer service and assistance to Participants regarding education and enrollment, Plan benefits, investment allocations, website and other Plan questions and assistance.
13. Provide technical, compliance, and educational support to the Plan Sponsor and Participating Employers and Eligible Participants.
14. Draft periodic Plan Sponsor/Participating Employer and Participant communications regarding legal and compliance updates, participant rights and responsibilities, and reminders regarding Plan benefits, policies, and procedures, etc.
15. Prepare and deliver notices and documents to Participants and Plan Sponsor/Participating Employers, as necessary, desirable, or required by law, including, but not limited to, communications contemplated for in the Investment Management Services described in Exhibit D, or as otherwise agreed.
16. Recommend and implement operational and compliance policies and procedures for the effective and efficient and compliant operation of the Plan.
17. Provide custodian and transfer agent services with respect to all Plan assets.
18. Assist with the investigation of errors reported to the Plan by a Plan Sponsor, Employer, or Participant.

Attachment F

HealthInvest HRA Plan Coverage Document
Full 213(d) Expense Coverage

Effective as of January 1, 2020

HealthInvest HRA
Plan Coverage Document

Post-separation Benefits Coverage
Effective as of January 1, 2020

Post-Separation Benefits Only
Full 213(d) Expense Coverage

ARTICLE I.
General Provisions

1.1 Name. The name of the Plan shall be the HealthInvest Health Reimbursement Arrangement "HRA" Plan (the "HealthInvest HRA Plan") of the Plan Sponsor and each Participating Employer. This Plan Coverage Document of the HealthInvest HRA Plan sets forth the terms and conditions for coverage that provides reimbursement of qualified IRC §213(d) expenses incurred after a Participant is retired or separated from service from the Employer and is referred to as the "Post-separation Benefits Plan" or "Post-separation Benefits" coverage. The HealthInvest HRA Plan may include one or more HRA plans or forms of HRA coverage from time to time the terms of which will be set forth and governed by a separate Plan Coverage Document applicable thereto. When used herein, the terms "Plan" or "HRA Plan" or "HealthInvest HRA Plan" shall refer to this Post-separation Benefits Plan either individually or collectively with other plans or forms of plan coverage included with the HealthInvest HRA Plan as the context indicates or requires.

1.2 Plan Documents. The HealthInvest HRA Plan Documents shall consist of all HealthInvest HRA Plan Coverage Documents, as applicable, the most current version of the Summary Plan Description, as the same may be amended from time to time, the Plan Adoption Agreement, the Master Trust, the Master Trust Adoption Agreement, the Trust Agreement, and, with respect to an Participating Employer, the applicable Employer Participation Agreement, and (with respect to a particular Participant) the individual Participant Enrollment File, all such documents collectively referred to as the "HealthInvest HRA Plan Documents." The Plan shall consist of the HealthInvest HRA Plan Documents and any Wrap Plan Documents of the Plan Sponsor. This Plan Coverage Document, any applicable Employer Participation Agreement, the individual Participant Enrollment File, the Plan Adoption Agreement, and any Wrap Documents set forth the terms and conditions for the HealthInvest Post-separation Benefits coverage. This Plan Coverage Document hereby amends, restates, and replaces all prior Plan Coverage Document versions governing HealthInvest HRA Post-separation Benefits coverage.

1.3 Definitions and Interpretation of Plan Documents.

1.3.1 Definitions. Defined terms used in this Plan Document and not otherwise defined herein are found in Appendix A hereto.

1.3.2 Terms Incorporated by Reference. Capitalized terms used herein and not defined herein shall have the meaning ascribed to such terms in the other HealthInvest

HRA Plan Documents. In the event of a conflict in the definition ascribed to any term in more than one HealthInvest HRA Plan Document, the conflict shall be resolved based upon the definition ascribed to such term in the document under which the provision in question references such term, and if not defined therein, then by reference to the definition ascribed to such term in the other Plan Documents as follows: first by reference to the Wrap Documents, then to the Master Trust, then to the Master Trust Adoption Agreement, then to this Plan document version, then to the Summary Plan Description, then to the Plan Adoption Agreement, then to the applicable Employer Participation Agreement, then to the applicable Enrollment File, then to the other Plan document versions, and then to the Trust Agreement.

1.3.3 Conflict in General Terms of Plan Documents. Collectively, the HealthInvest HRA Plan Documents are all parts of a single, integrated employee benefit system and shall be construed together. Except as specifically provided in Section 1.3.2, in the event of any conflict between the terms of this Plan document version and one or more of the Plan Documents, such conflict shall be resolved first by reference to the Wrap Documents, then to the Master Trust, then to the Master Trust Adoption Agreement, then to this Plan document version, then to the Summary Plan Description, then to the Plan Adoption Agreement, then to the applicable Employer Participation Agreement, then to the applicable Enrollment File, then to the other Plan document versions, and then to the Trust Agreement.

1.3.4 Construction and Interpretation of Plan Documents. Headings used in this Plan are inserted for convenience of reference only, and are not to be used in interpreting the provisions. References to or definition of any document, instrument or agreement, unless expressly noted otherwise, shall mean the same as amended, restated, supplemented, or otherwise modified from time to time. The words "including," includes," and "include" are used to mean without limitation. The word "or" is not exclusive. Wherever from the context it appears appropriate, each term stated in either the singular or plural shall include the singular and the plural, and pronouns stated in the masculine, feminine, or neuter gender shall include the masculine, feminine, and neuter genders.

1.4 Post-separation and Retiree-Only Plan. This Plan is a post-separation and retiree plan only. This Plan coverage is designed to provide Benefits 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). At the time a Participant separates from service from the Employer, the Participant will be covered under this Post-separation Benefits Plan. Benefits under this Plan shall be limited to expenses incurred by a Participant or Dependents only after the 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, as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer. Upon meeting such conditions, the Participant may file claims for Benefits. This Plan is a plan that covers less than two current employees and shall be considered a separate "retiree-only" plan for purposes of compliance with or exemption from certain provisions of federal law, including certain provisions of PPACA known as the Mandates.

1.5 Election to Forfeit Right to Benefits for Premium Tax Credit Eligibility. To the extent any Participant is Claims-Eligible and retains a positive account balance in his or her Participant Account during any month, PPACA provides that such Participant Account may generally constitute "minimum essential coverage," as defined under IRC §5000A, and may therefore preclude the Participant or his or her Dependents 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. To prevent a Claims-Eligible Participant Account from precluding a Participant or his or her Dependents from claiming or becoming entitled to an IRC §36B premium tax credit, a Participant may, at any time, elect to waive and forfeit the right to Benefits incurred on and after the date of such forfeiture election to and excluding the date on which such election is revoked by the Participant.

1.6 Election of Coverage under the Limited HRA Plan. In lieu of the forfeiture election permitted under Section 1.5, in order to become potentially eligible for an IRC §36B premium tax credit, a Participant with Post-separation Benefits coverage may, at any time, elect Limited HRA Coverage. Except as specifically (a) permitted by applicable law and (b) approved by the Administrator, any election under this Section 1.6 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.

ARTICLE II.
Participation

2.1 Eligibility; Commencement of Participation. In the Wrap Documents, the Plan Adoption Agreement, the Employer Participation Agreement, the Enrollment File, or other written instructions from the Employer, the Employer will designate those Employees or classes of Employees eligible to participate in the Plan, the Participant Eligibility Date, and any other requirements for Employees to become Participants and to become Claims-Eligible under the HealthInvest HRA Plan.

Subject to the limitations of this Article II:

2.1.1 General. An eligible Employee becomes a Participant under this Plan on the Participant Eligibility Date for such Employee; provided that, such Participant shall not be Claims-Eligible except as provided in Section 2.1.2 and 2.1.3 hereof.

2.1.2 Post-separation Benefits Coverage. A Participant described in Section 2.1.1 becomes Claims-Eligible under the HIHRA Plan and eligible for Post-separation Benefits coverage upon receipt by the Plan of (a) the Enrollment File for such Participant and (b) written instructions or other notification to the Plan that the Participant has retired from employment or separated from service with the Employer and satisfied all other conditions for eligibility to receive Post-separation Benefits and file claims as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

2.1.3 Limited In-service (Excepted Benefits) Coverage. Depending on the Employer's Plan design or elections, a Participant described in Section 2.1.1 may become

Claims-Eligible under the HIHRA Plan and eligible only for Excepted Benefits coverage on the Participant Eligibility Date pursuant to the terms and conditions of the Limited HRA Plan. In such case, the Participant shall subsequently become eligible for Post-separation Benefits coverage, upon receipt by the Plan of written instructions or other notification to the Plan that the Participant has retired from employment or separated from service with the Employer and satisfied all other conditions for eligibility to receive Benefits and file claims as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer. During any period in which the Participant is eligible pursuant to this Section for Excepted Benefits coverage under the Limited HRA Plan, the Participant shall have the right to decline or revoke coverage under the Limited HRA Plan by notifying the HRA Service Manager or other Plan Representative by phone or in writing.

2.2 Rehire Restriction on Claims-Eligibility.

2.2.1 If after a Participant becomes Claims-Eligible for Benefits under this Post-separation Benefits Plan as described in Section 2.1.2 or Section 2.1.3, and such Participant subsequently becomes Re-employed by the Employer, then, during any period that the Participant is Re-employed, the Participant shall not be covered or eligible for Benefits under this Post-separation Benefits Plan, but shall instead be eligible for Benefits as follows:

2.2.1.1 To the extent there is a remaining balance attributable to contributions originally made to a Participant Account that permits In-service Benefits coverage, then for that remaining balance, during the period of Re-employment, the Participant shall be covered and eligible for Benefits under and according to the terms and conditions of the In-service Benefits Plan document version.

2.2.1.2 To the extent there is a remaining balance attributable to contributions originally made to a Participant Account that permits Post-separation Benefits coverage or Limited HRA Coverage only, then for that remaining balance, during the period of Re-employment the Participant shall be covered and eligible only for Excepted Benefits under the Limited HRA Plan according to the terms and conditions of the Limited HRA Plan document version.

2.3 Duration of Participation. Once a Participant becomes Claims-Eligible under the Plan, the Participant's active status with respect to any Participant Account shall exist for so long as there is a positive account balance in such Participant Account, and thereafter, for such period as determined under the policies and procedures of the Administrator ("Account Closure Period"), but not to exceed two (2) years. If a Participant Account remains exhausted for the Account Closure Period, the Participant's active status with respect to such Account shall terminate after such Account Closure Period in accordance with the Plan's policies and procedures. A Participant who has lost his or her active status with respect to any Participant Account may subsequently become a Participant in the Plan and Claims-Eligible as prescribed in Section 2.1. During any Account Closure Period for any Participant Account, a Participant may or may not receive

statements or other plan communications with respect to such Participant Account, but will remain Claims-Eligible.

2.4 Nondiscrimination. The Plan is intended to comply with all nondiscrimination laws applicable to eligibility under, contributions to, and Benefits of, the Plan (including any such rules prescribed by IRC §105(h)).

ARTICLE III.
Funding or Allocation of Benefits

3.1 Contributions. The Employer, or the Plan Sponsor on behalf of the Employer, may make one or more contributions to the Plan, or transfer assets from other benefit plans, with respect to eligible Employees pursuant to the terms of Wrap Documents, collective bargaining agreements, Employer policies, or other legal or contractual obligations of the Employer. Contributions or transfers to the Plan shall be specifically allocated to one or more Participant Accounts or maintained in an Employer Account for the purpose of paying Benefits or for other purposes permitted by and described in the Plan Documents. The Plan may accept amounts transferred from another welfare benefit plan maintained for the benefit of Employees, provided that no such transfer will be permitted based on the election or direction of any individual Employee or that would otherwise cause the Plan to be treated as anything other than a health reimbursement arrangement qualifying under IRC §§105 and 106. Except for any contributions that constitute COBRA continuation premiums paid by Employees or Dependents, no individual Employee contributions or direct or indirect salary reduction contributions elected by individual Employees will be permitted. All deposits, transfers, and other contributions (including COBRA contributions from Participants and Dependents, if any) shall be on the terms acceptable to the Administrator and pursuant to rules, policies and procedures established by the Administrator.

3.2 Administration of Contributions. All contributions and other amounts transferred to the Plan shall be held in a custodial account by or on behalf of the Plan and invested, administered, and distributed in accordance with the terms of the Plan. Neither the Administrator, HRA Service Manager, nor any other of the Plan Representatives shall be under any duty to inquire into the timeliness or correctness of the amounts contributed to the Plan, or to confirm or enforce the payment of contributions to the Plan or terms of any Wrap Documents, collective bargaining agreement, policy, or other agreements or obligations regarding the terms of eligibility to participate in the Plan or amounts to be contributed on behalf of a Participant. No provision of this Plan shall be construed as requiring the Employer or Plan Sponsor to make or continue to make contributions to the Plan. Nothing in this Plan shall entitle the Administrator, HRA Service Manager, Plan Representatives, or Participants to inquire into or demand the right to inspect the books of the Employer.

3.3 Use of Plan Assets. Except as otherwise provided herein or in the Plan Adoption Agreement, Plan assets shall be used exclusively to pay Benefits and obligations under the Plan and to defray reasonable expenses of administering the Plan, including to the fullest extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Plan, the Plan Sponsor (in its capacity as Administrator or Plan Sponsor), the Employer, or Participants,

that may be paid through reasonable fees and assessments from Plan assets, including Participant Accounts.

3.4 Limitation on Rights. Except as otherwise provided herein and in the Plan Adoption Agreement, no person shall have any rights with respect to Plan assets allocable to any Participant Account except the rights of Participants, Dependents, and any other persons entitled to receive Benefits under such Participant Account in accordance with the terms, and subject to the limitations of, the Plan and applicable law, and no such person shall be considered to have any legal or equitable ownership interest in any assets of the Plan. The rights of a Participant, Dependent, or any other person entitled to receive Benefits from a Participant Account, shall not be subject to assignment or alienation, either by voluntary or involuntary act of the person or by operation of law and shall not be subject to attachment, execution, garnishment, or any other legal or equitable process except to the extent required by law.

ARTICLE IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Plan to reflect the contributions, income, losses, increases and decreases for expenses or benefit payments attributable to each Participant Account and Employer Account, and for the Plan in the aggregate.

4.2 Receipt and Allocation of Contributions and Transfers. Contributions and transfers will be credited as received by the Plan and are to be allocated based upon instructions from the Employer or Plan Sponsor. If a complete Enrollment File or investment election instructions have not been submitted for any amount allocated by the Participating Employer or Plan Sponsor to a Participant Account, the contribution may be allocated to a non-interest bearing account for unallocated funds or to one or more default investment funds designated by the Plan Sponsor until such time as a complete Enrollment File or investment election instructions are submitted by the Participant. If any portion of any contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Participating Employer or Plan Sponsor, the contribution may be allocated to a non-interest bearing account for unallocated funds or to one or more default investment funds until such time as further instructions are received from the Employer or Plan Sponsor. Upon determining that any portion of any contribution is not allocable to a specific Participant Account or an Employer Account, the HRA Service Manager shall notify the Participating Employer or Plan Sponsor within five (5) business days following the HRA Service Manager's reasonable and customary efforts to obtain such instructions. The Participating Employer or Plan Sponsor shall provide the HRA Service Manager with written instruction on how to handle such contributions within five (5) business days of receiving such request. The Plan Sponsor's or Participating Employer's instructions shall direct the HRA Service Manager to distribute the non-allocated portion of these contributions in a manner deemed appropriate at the sole discretion of the Plan Sponsor or the Participating Employer, provided that such instructions are not inconsistent with the rules governing the Trust Agreement or the Plan Sponsor's participation in the Master Trust. The written instructions from the Plan Sponsor or Participating Employer may include, but are not limited to: (1) the instruction to place unallocated contributions into a non-interest bearing account for unallocated funds or to

one or more default investment funds designated by the Plan Sponsor, as appropriate based on existing circumstances; or (2) the instruction to return the unallocated contribution to the Participating Employer. If the HRA Service Manager does not receive direction from the Employer or the Plan Sponsor within the timeframes indicated above, the HRA Service Manager shall have the right to return such funds to the Employer or Plan Sponsor, as applicable. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior benefit plan on behalf of an Employee for whom an Enrollment File is not submitted will not be returned to the Employer and will be treated as directed by the Plan Sponsor or Employer in writing and in accordance with the policies and procedures established by the Administrator.

4.3 Accounting Steps. The HRA Service Manager shall:

4.3.1 Allocate and credit any contribution to this Plan to a Participant Account or an Employer Account within two (2) business days of receipt of an electronic contribution or transfer and within five (5) business days of receipt of a paper check contribution or transfer.

4.3.2 At the end of each Valuation Period, adjust each Participant Account and Employer Account upward or downward, by an amount equal to the net income or loss accrued under this Plan with respect to such Account.

4.3.3 At the end of each Benefit Payment Period, charge to each Participant Account payments or distributions made under this Plan to or for the benefit of the Participant for Participant Accounts or the Employer for Employer Accounts.

4.3.4 Charge to each Participant Account and Employer Account applicable fees that are allocable to the account that have not been charged previously.

4.4 Investment of Participant Accounts and Employer Accounts. The Plan will provide one or more paper forms or other online or mobile application methods by which an Employer or Participant may direct the investment options into which funds in any Employer Account or Participant Account shall be invested. For Participant Accounts designated by the Plan Sponsor for Participant-directed investing, each Participant shall be responsible for the investment decisions for his or her Participant Account and shall elect one or more investment options into which funds contributed to his or her Participant Account or Accounts will be invested. For Employer Accounts designated by the Plan Sponsor or Participating Employer for Employer-directed investing, the Employer shall be responsible for the investment decisions for its Employer Account and shall elect one or more investment options into which the funds contributed to the Employer Account will be invested, subject to any investment limitations prescribed by applicable law. Investment elections shall be made and changed in accordance with procedures established for the Plan, as such procedures may be amended from time to time. In the event an Enrollment File has been received with respect to a Participant but no investment election has been made with respect to the Participant Account, or no investment election has been made by the Employer with respect to an Employer Account, that Account shall be invested in one or more default investment options. The Plan shall not be required to maintain separate investments with respect to separate Participant Accounts or Employer Accounts, and all Plan assets may be invested in an omnibus

account with securities registered in the name of a nominee, trustee, custodian, or transfer agent as permitted by the Plan Adoption Agreement. Notwithstanding the foregoing, the HRA Service Manager, on behalf of the Administrator, shall maintain separate and distinct sub-accounting records for each Participant Account and Employer Account so that such accounts will be credited with divided interests in the specific investments allocable thereto.

4.5 Use of Participant Accounts. Amounts credited to a Participant Account shall be available to provide Benefits with respect to the Participant or his or her Dependents at such times as specified in the Plan Adoption Agreement and other Plan Documents, provided the Participant has satisfied any vesting and claims-eligibility requirements, and the HRA Service Manager shall be entitled to rely on verification from the Employer or the Participant that such requirements have been met. Any amounts allocated to a Participant Account that are forfeited pursuant to the terms of the Plan Documents will be reallocated to other Participant Accounts or an Employer Account, or returned to the Employer, as provided in the Plan Adoption Agreement and permitted by the applicable Trust Agreement, and applicable law.

4.6 Use of Employer Accounts. Amounts credited to an Employer Account are to be applied in any manner permitted under the Plan Adoption Agreement, Trust Agreement, and applicable law.

4.7 Splitting Participant Account Upon Court Order or Agreement. To the extent permitted 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 decree, and subject to the policies and procedures of the HRA Service Manager; provided, however, the Administrator or HRA Service Manager shall have the right not to split such account if the splitting of accounts upon divorce could result in disqualification of or adverse tax consequences for the Plan or Trust. The HRA Service Manager may develop policies and procedures to value, report, withhold, and pay applicable taxes or other fees and charges in accordance with the Plan Documents and applicable law, and to the extent permitted by law, the same shall be conclusive and binding upon the Participant and his or her former Spouse.

4.8 Notify the Plan of Errors within Ninety (90) Days. Participants, the Plan Sponsor, and the Employer should regularly review account information and immediately report any potential errors to the Plan. Participants, Plan Sponsors, and Employers must notify the Plan of an account error within ninety (90) days from the date the potential account error (a) is viewed by the applicable Participant or the Plan Sponsor or Employer online through the Plan portal or (b) appears on an account statement or other report received by the applicable Participant or the Plan Sponsor or Employer, whichever occurs first ("Notification Period"). The Plan Sponsor or Employer may, but shall not have an obligation to, notify the Plan of any error relating to a Participant Account, with it being the sole responsibility of the Participant to regularly review his or her account and notify the Plan of any errors. Notification of any potential errors should be in writing in accordance with Section 4.8.1 below.

4.8.1. Contents of Error Notification. Written notice of any potential account error must include: (1) the name of the Plan Sponsor and/or 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 the Plan Sponsor or Employer believes it to be an error.

4.8.2 Investigation of Error; Corrective Action. The Administrator or its designee will perform a timely investigation of any error notifications. The affected parties 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 HRA Service Manager. Correction of any errors will be applied prospectively and, retroactively for any losses incurred during the Notification Period defined by this Section 4.8, including any investment losses, if such losses are the direct result of the negligent error or omission on the part of the Plan or its representatives. However, neither the Plan, nor any Plan Representative shall be liable for losses incurred by a Participant or the Plan Sponsor or Employer, as applicable, after expiration of the Notification Period.

4.9 Reliance upon Data and Information from Participants, Plan Sponsor, and Employer. It is the responsibility of Participants and the Plan Sponsor or 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 the Plan Sponsor or Employer as true and correct. The Plan and its agents are not responsible for any errors made by a Participant or the Plan Sponsor 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 the Plan's reliance upon incorrect data or information submitted by a Participant or the Plan Sponsor or Employer. If a Participant or the Plan Sponsor or Employer discovers that information or data submitted to the Plan was incorrect, it is the responsibility of that Participant or the Plan Sponsor of Employer to timely notify the Plan in writing and correct the information or data.

4.10 Forfeited or Unclaimed Accounts. In an effort to preserve Participant Accounts from becoming unclaimed or forfeited, the HRA Service Manager may implement policies and procedures to locate Participants. In each instance for which a Participant (1) has combined account balances greater than $250 and (2) for a period of at least six months has met the conditions set forth under Sections 4.10.2.1 – 4.10.2.4 and has otherwise been unreachable by the Plan, the HRA service Manager may engage third-party services to locate the Participant. Reasonable fees and expenses incurred by the HRA Service Manager in its effort to locate a Participant under the foregoing circumstances may be charged against one Participant Account up to an amount not to exceed the lower of $100 or 20% of the combined account balances. Notwithstanding the above, if a positive balance remains in any Participant Account under any of the following circumstances, the remaining balance in such Participant Account shall be forfeited and applied as directed in the Plan Adoption Agreement or as otherwise directed by the Plan Sponsor or Employer, in all cases to the fullest extent permitted by applicable law and subject to the rules and policies and procedures established by the HRA Service Manager:

4.10.1 After the death of the Participant and at a time when there are no Dependents or other persons entitled to receive Benefits from such Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer) as described in Section 5.3.

4.10.2 If, in accordance with the policies and procedures of the Plan, the HRA Service Manager has determined the participant is not locatable and, during a continuous period equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for the Participant Account and (ii) three years, the following conditions exist:

4.10.2.1 Such Participant Account is vested and Claims-Eligible;

4.10.2.2 No contributions to or withdrawals from the Participant Account have occurred;

4.10.2.3 No communications or other expressions of interest have been received by the Plan from or on behalf of the Participant; and

4.10.2.4 During such period at least two communications from the Plan to the Participant have been returned as undeliverable.

4.10.3 After the Participant for whom such Participant Account is established shall have been unable to submit claims for reimbursement pursuant to Section 5.1.2 hereof for at least three years from the Claims Eligibility Date for such Participant because the Plan has not received a complete Enrollment File for such Participant.

4.10.4 Any other circumstance specified in this Plan or the Plan Adoption Agreement that results in the forfeiture of the account balance in any Participant Account.

ARTICLE V.
Qualified Health Care Expenses and Post-separation Benefits Coverage

5.1 Benefits for Qualified Health Care Expenses. Post-separation Benefits coverage includes reimbursement for medical care expenses as defined by IRC §213(d) and IRC §106(f) 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 the Plan Documents, applicable law, or as otherwise provided in policies and procedures of the Administrator or HRA Service Manager. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under the terms of this Plan Document version. Benefits may include (but are not limited to) Premium Reimbursements 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 healthcare flexible spending account which provides the same type of benefits as are covered under this Plan must exhaust benefits under the IRC §125 healthcare flexible spending account prior to filing a request for 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 due to limitations imposed or other benefits allowed under applicable law. Limited HRA Coverage shall be subject to the terms and conditions of the Limited HRA Plan document version, limitations and provisions of applicable law, and the rules, regulations and limitations established by the Administrator or HRA Service Manager from time to time. During any period in which the Participant is automatically eligible for or has elected coverage under the Limited HRA Plan, the Participant shall have the right to decline or revoke coverage under the Limited HRA Plan by notifying the HRA Service Manager or other Plan Representative by phone or in writing.

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.

5.1.1.5 Except as otherwise provided under Article II, Benefits under this Post-separation Benefits Plan are not permitted for any Qualified Health Care Expenses incurred prior to the date a Participant becomes Claims-Eligible and retired or otherwise separated from service from the Employer who made or caused contributions to be made on behalf of the Participant or for Qualified Health Care Expenses incurred during any period that a Participant is Re-employed with the Employer who made or caused contributions to be made on behalf of such Participant.

5.1.2 Claims for Benefits. Subject to the terms and conditions of this Plan Document, Participants are entitled to Post-separation Benefits coverage for Qualified Health Care Expenses incurred on or after the date they become Claims-Eligible, provided that the Administrator may require, as a condition to the payment of Benefits, any information necessary for the Plan or 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).

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

5.1.4 Premium-Only and Other Limited Use Accounts.

5.1.4.1 Pursuant to an election of the Plan Sponsor or Participating Employer in the Plan Adoption Agreement, the Plan Sponsor or Participating Employer may limit one or more Participant Accounts of any group of Participants to Premium Reimbursements only. For any such election under this Post-separation Benefits Plan, Premium Reimbursements shall be limited to reimbursement for out-of-pocket, after-tax payments for (1) health insurance premiums for a Participant and his or her Dependents to insurance companies or insurers; (2) premiums for qualified long-term care insurance for a Participant and his or her Dependents; and (3) premiums for any part of Medicare for a Participant and his or her Dependents. Premium Reimbursements under a premium-only election may not include reimbursement for any type of contribution or other payments made to self-insured health plans, including COBRA coverage or other contributions for coverage under the Employer's or Plan Sponsor's self-insured health plans.

5.1.4.2 In addition, the Plan Sponsor may, pursuant to an election or amendment of the Plan Adoption Agreement, impose any other limitations or restrictions on the payment of Benefits as necessary or desirable to coordinate with other benefit plans of Participants or to comply with applicable laws or regulations.

5.1.5 COBRA. Participants or Dependents have a right to continue to make contributions and/or receive Benefits under this Plan for a specified time period if such rights are lost due to certain qualifying events, as prescribed by COBRA. COBRA continuation coverage for certain qualifying events is dependent on the Plan receiving notification of qualifying events within certain time periods as prescribed by COBRA. The Plan will administer continuation of COBRA using policies and procedures required or permitted by COBRA.

5.2 Health Care Debit Cards. Participants in the HRA Plan may, subject to the procedures established by the Administrator, use the Card(s) provided by the Administrator for payment of Benefits, subject to the provisions below.

5.2.1 Each Participant, by participating in the Card Program and by using the Card(s), certifies that such Card shall only be used for Benefits and that any Benefit paid with the Card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

5.2.2 The Card shall be issued upon the Participant becoming Claims-Eligible, and is valid until reissued or replaced and for so long as the Participant remains a Participant in the Plan. The dollar amount of coverage available on the Card shall be subject to policies and procedures of the Administrator. Participant shall not use the Card to pay claims in excess of the dollar amount available on the Card.

5.2.3 The Cards shall only be used for permitted Benefits.

5.2.4 Participant shall be subject to the terms and conditions of the cardholder agreement, which shall be distributed with the Card.

5.2.5 Purchases made with the Cards shall be subject to the substantiation requirements of the Administrator. The Administrator, in its sole discretion, shall adopt procedures to ensure that amounts paid with the Card qualify as eligible Benefits under the Plan. Substantiation may be accomplished in accordance with policies and procedures of the Administrator, including without limitation, by Participant's submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase, and the amount. Some charges shall be considered substantiated at or after the time of the Card charge by the nature of the charge and information collected at the time of the charge. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously substantiated as to amount, provider, and time period. At the point of sale, the service provider or merchant can provide or make available to the Administrator information to substantiate the charge. All charges not automatically adjudicated shall be conditional, pending confirmation and substantiation.

5.2.6 Participants shall maintain records to substantiate payments of Benefits made with Cards. If the Card is used to pay an expense that is not automatically adjudicated or otherwise independently verified without additional documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Administrator to verify that the amount was an eligible Benefit. If the Participant fails to provide information to satisfy the Administrator that amounts paid by use of the Card are eligible Card Services, the Administrator may, in its discretion, make the Plan whole by taking whatever action it deems appropriate to require the Participant to repay the amount that has not been verified, including:

(a) requesting the Participant to reimburse the Plan for the amount that has not been verified;

(b) offsetting future reimbursement of claims by the amount paid by use of the Card that has not been verified;

(c) suspending the activation on the Participant's Card; and

(d) suspending the Participant's eligibility to use the Card and participate in the Plan.

If the Administrator's correction efforts prove unsuccessful, the Participant remains indebted to the Plan for the amount of the payment that has not been verified. In that event, and consistent with its business practices, the Plan may treat the amount that has not been verified as it would any other business indebtedness. If the payment is not recovered within the timeframes specified in the policies and procedures of the Administrator, then the Plan may forgive the indebtedness, in which case the payment shall be reported as taxable income for the year in which the indebtedness is forgiven.

5.2.7 The Administrator, in its sole discretion, may adopt such other rules that it deems appropriate to govern the use of the Card to pay eligible Benefits (*e.g.*, establishing transaction limits on the Card, charging fees to use such Cards, etc.).

5.2.8 The Card is subject to cancellation upon the following: Participant's death; Participant's termination of his or her participation in the HRA Plan; Employer's termination of participation in the Plan; Participant's failure to produce proper forms and supporting documentation required for substantiation of the expense paid with the Card; or if Participant breaches any of his or her obligations under the cardholder agreement.

5.3 Benefits Available in the Event of Death.

5.3.1 Standard HRA Survivor Benefit. For Plan Sponsor or Employer Plans that do not qualify for an Extended Survivor Benefit under Section 5.3.2, the following rules shall apply. If a Participant dies with a vested, positive account balance in any Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer), his or her surviving Spouse may file claims for Benefits incurred by the Participant and any Dependents until such account balance is exhausted. If a Participant dies without a surviving Spouse and with other Dependent(s), then the executor or administrator of the Participant's estate may file claims for any eligible expenses incurred by the Participant, and the Dependent(s) (or the guardian(s) of the Dependent(s)) may file claims for eligible Benefits on behalf of the Dependent(s) until such account balance is exhausted. If a vested, positive account balance remains in any Participant Account at a time when there are no surviving Dependents of the deceased Participant (including the surviving Spouse) or other survivors who may under applicable law be entitled to Benefits from a Participant Account, then the remaining balance in such Participant Account shall be applied in accordance with Section 4.10. The provisions of this section shall be administered pursuant to rules established by the Administrator.

5.3.2 Extended HRA Survivor Benefit. In the limited circumstances where an Employer or Plan Sponsor's Plan qualifies for an extended survivor benefit ("Extended Survivor Benefit"), the rules applicable to such Extended Survivor Benefit will be located on the Employer and Participant online portal or upon request from the HRA Service Manager.

ARTICLE VI.
Additional Regulatory Provisions

6.1 Procedures for Claims, Internal Appeals, and External Review. The following provisions of this Section 6.1 set forth the minimum procedures for claims, internal appeals of Adverse Benefits Determinations, and external review of Final Internal Adverse Benefits Determinations required by law. These procedures shall be followed by the Administrator, its agents and subcontractors, and each Claimant under this Plan, and no judicial proceedings with respect to any request for Benefits hereunder may be commenced by any such Claimant until the

procedures for claims and internal appeals of Adverse Benefits Determinations set forth herein have been followed and exhausted in full; provided, however, that any timeframe requirements or limitations applicable to the Plan or the Administrator may be voluntarily extended in writing by the Claimant in the Claimant's sole discretion, and any timeframe requirements or limitations applicable to the Claimant may be voluntarily extended in writing by the Administrator in the Administrator's sole discretion.

6.1.1 Claims. A person claiming Benefits under the Plan, which may include a Participant, Dependent, or any other covered individual as permitted by applicable law, or any such person's authorized representative (referred to in this section as the "Claimant"), shall deliver a request or claim for such Benefits in writing to the Plan. The Plan shall review the Claimant's request or claim for Benefits and shall thereafter notify the Claimant of its decision as follows:

6.1.1.1 The Plan shall provide the Claimant with written notice of its determination regarding the Claimant's request for Benefits not later than thirty (30) days after the date the Plan receives the Claimant's request for Benefits, unless circumstances beyond the control of the Plan require an extension of time for reviewing such claim. In the event such circumstances require an extension of time for reviewing the Claimant's request for Benefits, the Plan shall, prior to the expiration of the initial thirty (30)-day period referred to above, provide the Claimant with written notice of the extension and of the circumstances that require such extension and of the date by which the Plan expects to render its determination. In no event shall such extension exceed a period of fifteen (15) days after the date of the expiration of the initial thirty (30)-day period, totaling forty-five (45) days at a maximum after the date the Plan receives the Claimant's request for Benefits (such thirty (30) or forty-five (45) day period being referred to herein as the "Initial Review Period").

6.1.1.2 If the Claimant's request for Benefits is approved by the Plan, the Plan shall notify the Claimant of such approval and proceed to process the request for Benefits.

6.1.1.3 In the event the Plan determines that additional information is required to review a claim, the Plan shall provide the Claimant with written notice of its need for additional information ("Notice of Incomplete Claim") as soon as practicable, but not later than the expiration of the applicable Initial Review period and the need for an extension of time to allow the Claimant sufficient time to gather and provide such additional information. The Notice of Incomplete Claim shall specifically describe the required information and provide the Claimant with at least forty-five (45) days after the date the Claimant receives such Notice of Incomplete Information (the "45-Day Response Period") to provide such additional information to the Plan. If the Claimant fails to respond with additional information before the expiration of the 45-Day Response Period, the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of the 45-Day Response Period, and the Notice of

Incomplete Claim may include a provisional Adverse Benefits Determination that would take effect automatically under such circumstances. If, within the 45-Day Response Period, the Claimant provides additional information (whether or not such additional information is determined by the Plan to be sufficient to make a benefits determination), then the Plan shall provide the Claimant with written notice of its determination not later than fifteen (15) days after the date the Plan receives such additional information, regardless of whether either the Initial Review Period or the 45-Day Response Period will not yet expire prior to such fifteen (15) day period (such new review period shall be referred to herein as the "Incomplete Claim Review Period" and shall override the Initial Review Period under the circumstances described in this paragraph).

6.1.1.4 In the event of an Adverse Benefits Determination, the Plan shall provide written notice of such Adverse Benefits Determination and shall include in such notice, set forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant, the following:

(a) The specific reason or reasons for the Adverse Benefits Determination and sufficient information to identify the claim involved, if any, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to pertinent Plan provisions or IRS rules and regulations on which the Adverse Benefits Determination is based;

(c) An explanation of the Claimant's right to appeal such Adverse Benefits Determination and to have such appeal reviewed by someone other than (i) the original individual who made the initial Adverse Benefits Determination or (ii) such original individual's subordinate;

(d) A description of any additional material or information necessary for the Claimant to perfect the claim or appeal the Adverse Benefits Determination and an explanation of why such material or information is necessary;

(e) An explanation of the Claimant's right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process;

(f) A description of available internal appeals procedures, including information regarding how to request a review of an Adverse Benefits Determination pursuant to Section 6.1.2 below and the timeframe within which to submit such a request;

(g) At no cost to the Claimant, copies of any additional evidence considered, relied upon, or generated by the Plan in connection with its review of the claim and an opportunity for the Claimant to respond to such additional evidence within the one hundred eighty (180)-day time period within which to appeal the Adverse Benefits Determination as described in Section 6.1.2.

(h) An explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

6.1.1.5 In the event that neither an approval of Benefits nor Adverse Benefits Determination is received or deemed received by the Claimant before the expiration of the Initial Review Period or the Incomplete Claim Review Period (whichever is applicable), the claim shall be deemed to have received an Adverse Benefits Determination as of the day immediately following the expiration of such applicable review period.

6.1.2 Health Care Debit Card Transactions are Not Claims. The presentation or use of a Card for payment at a merchant or vendor is not considered a submission of a formal claim under the Plan. In the event the merchant or vendor denies the transaction or the transaction is unable to be processed at the point of sale with that merchant or vendor, such denial of the transaction at the point of sale shall not be considered a denial under the Plan. If the transaction is approved at the point-of-sale, but the transaction is not electronically validated at the point of sale or later independently substantiated without further documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Third-party Administrator to verify that the amount was an eligible expense reimbursable by the Plan. Where the Third-party Administrator determines that an expense is not eligible to be paid with the Card because the Participant or Dependent has not submitted the information requested by the Third-party Administrator to substantiate the claim as an expense reimbursable under the Plan (*e.g.,* where the Card is suspended, the Plan requests reimbursement of the unsubstantiated expense and/or the Plan applies an overpayment against the applicable Participant Account and offsets against future claims), then denial of such Card payment would become a denial subject to the formal claims and appeals procedures under this Section.

6.1.3 Internal Appeals of Adverse Benefits Determinations.

6.1.3.1 In the event an Adverse Benefits Determination has been received or deemed received by a Claimant, the Claimant may appeal such Adverse Benefits Determination by submitting to the Plan a written request for a review of such Adverse Benefits Determination. Any such written request for review must be delivered to the Plan not later than one hundred eighty (180) days after the date the Claimant receives written notification of the Adverse Benefits Determination or from the date the Claimant was deemed to have received an Adverse Benefits Determination for such claim.

6.1.3.2 During the period prescribed in paragraph 6.1.3.1 for filing a request for review of an Adverse Benefits Determination, the Plan shall permit the Claimant to review the claim file and other pertinent documents and submit written issues and comments concerning the Claimant's claim.

6.1.3.3 Upon receiving a request by a Claimant for a review of an Adverse Benefits Determination, the Administrator, or one or more representatives designated by the Administrator, shall review such Adverse Benefits Determination promptly, and shall provide written notice to the Claimant of its determination within sixty (60) days after the date on which the Plan received the request for review of such Adverse Benefits Determination.

6.1.3.4 If the Claimant's request for Benefits is approved by the Plan upon review of the Adverse Benefits Determination, the Plan shall notify the Claimant of such approval and proceed to process the request for Benefits.

6.1.3.5 If in connection with its review of an Adverse Benefits Determination, the Administrator or its designees considered, relied upon, or generated any new or additional evidence or rationale for a Final Internal Adverse Benefits Determination, the Plan shall, as soon as practicable but not later than thirty (30) days after the date the Plan receives the Claimant's request for review of such Adverse Benefits Determination, provide the Claimant with written notice of such new evidence or rationale ("Notice of New Information") and the opportunity for the Claimant to provide a written response to such new evidence or rationale not later than fifteen (15) days after date the Claimant receives such Notice of New Information (the "15-Day Response Period"). If the Claimant fails to provide a written response before the expiration of the 15-Day Response Period, the claim shall be deemed to have received an Final Internal Adverse Benefits Determination as of the day immediately following the expiration of the 15-Day Response Period, and the Notice of New Information may include a provisional Final Internal Adverse Benefits Determination that would take effect automatically under such circumstances. If within the 15-Day Response Period, the Claimant provides a written response to such new evidence or rationale, then the Administrator or its designees shall review such new evidence or rationale and the Plan shall provide the Claimant with written notice of its determination not later than (i) fifteen (15) days from the date of the Plan's receipt of such written response or (ii) sixty (60) days from the date on which the Plan received the request for review of such Adverse Benefits Determination, whichever occurs first.

6.1.3.6 The Plan shall provide written notice to the Claimant of a Final Internal Adverse Benefits Determination and shall include in such notice, set

forth in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant the following;

(a) The specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes;

(b) Specific references to the pertinent Plan provisions or IRS rules and regulations on which the Final Internal Benefits Determination is based.

(c) A description of available external review procedures, including information regarding how to request an external review of the Final Internal Adverse Benefits Determination pursuant to Section 6.1.4 below and the timeframe within which to submit such a request; and

(d) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist Claimants with the external review procedures.

6.1.3.7 In the event that neither an approval of Benefits nor a Final Internal Adverse Benefits Determination is received or deemed received by the Claimant within sixty (60) days after the date the Plan receives the written request for review of the Adverse Benefits Determination, the claim shall be deemed to have received a Final Internal Adverse Benefits Determination as of the sixty-first (61st) day following the date Plan received the written request for review of the Adverse Benefits Determination.

6.1.4 External Review of Final Internal Adverse Benefits Determinations.

6.1.4.1 After receipt or deemed receipt of a Final Internal Adverse Benefits Determination, a Claimant may file a written request for an external review of such Final Internal Adverse Benefits Determination. Any such request for review must be delivered to the Plan not later than the first day of the fifth month following the date the Claimant receives or is deemed to receive a Final Internal Adverse Benefits Determination. If such request for external review deadline falls on a Saturday, Sunday, or other non-business day, then the request for external review must be delivered to the Plan not later than the next calendar day that is not a Saturday, Sunday, or other non-business day (the "Initial External Review Filing Deadline").

6.1.4.2 Within five (5) business days after receiving the external review request, the Plan must complete a preliminary review to determine if:

(a) the Claimant was covered under the Plan

(b) the Claimant provided all the information and forms necessary to process the external review,

(c) the Claimant has followed and exhausted the internal appeals procedures, and

(d) the Final Internal Adverse Benefits Determination related to the failure of the Claimant to meet eligibility requirements under the Plan, as Final Internal Adverse Benefits Determinations based upon a failure to meet eligibility requirements are not subject to external review.

6.1.4.3 Within one (1) business day after completion of its preliminary review, the Plan shall provide written notice to the Claimant of the outcome of its review. If the Claimant's request for external review is complete but the Final Internal Adverse Benefits Determination is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If the Claimant's request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and the Claimant shall be permitted to complete the request not later than the Initial External Review Filing Deadline or forty-eight (48) hours after the Claimant's receipt of the preliminary review notice, whichever is later.

6.1.4.4 If the Plan receives a timely, completed request for external review of a Final Internal Adverse Benefits Determination that is eligible for review in accordance with the requirements of this Section 6.1.3, the Plan shall assign an Independent Review Organization (IRO) to review the claim, using a method of assignment that assures the independence and impartiality of the assignment process. The IRO shall be required to provide written notice to the Claimant stating that:

(a) The Claimant's request is eligible for external review and has been assigned to such IRO;

(b) The Claimant has the right to submit additional information in writing to the IRO within ten (10) business days after the date the Claimant receives such notice and, if the IRO receives such additional information within ten (10) business days after the Claimant receives such notice, then (i) the IRO must consider such additional information in its external review, and (ii) the IRO is required to forward such additional information submitted by the Claimant to the Plan within one (1) business day after the date the IRO receives such information;

6.1.4.5 Within five (5) business days after the date the IRO receives the external review assignment, the Plan is required to provide the IRO with all documents and information considered by the Plan in making its Adverse Benefits Determination and Final Internal Adverse Benefits Determination;

6.1.4.6 Upon receiving from the IRO any additional information submitted by the Claimant, the Plan may reconsider the Final Internal Adverse Benefits Determination. If the Plan reverses the Final Internal Adverse Benefits Determination upon such review, it must notify the Claimant and the IRO within one (1) business day after making such reversal, and the IRO must terminate its external review;

6.1.4.7 The IRO is not bound by the prior Adverse Benefits Determination or Final Internal Adverse Benefits Determination of the Plan in making its external review decision.

6.1.4.8 Within forty-five (45) days after the IRO receives the external review request, the IRO must provide written notice of the final external review decision to the Claimant and the Plan. Such notice shall include the following information:

(a) A general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial;

(b) The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision;

(c) References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;

(d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;

(e) A statement that the IRO's decision is binding unless other remedies are available to the Plan or the Claimant under state or federal law;

(f) A statement that judicial review may be available to the Claimant; and

(g) A phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

6.1.4.9 An external review decision by the IRO upholding the Plan's Final Internal Adverse Benefits Determination is binding on the Claimant but does not prohibit the Claimant from subsequently pursuing other remedies available under state or federal law. If the IRO reverses the Plan's Final Internal Adverse Benefits Determination, the Plan is required by law to provide reimbursement for the claim without delay; provided, however, that the Plan shall still be entitled to subsequently pursue other legal remedies that may be available under state or federal law.

6.2 Protected Health Information. The Plan 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).

6.2.1 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:

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

6.2.1.2 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;

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

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

6.2.1.5 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;

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

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

6.2.2 Plan Sponsor and Employer Uses of Protected Health Information.

6.2.2.1 HIPAA Plan Amendment. Members of the workforce of an Employer or Plan Sponsor may have access to the individually identifiable health information of Participants for administration functions of the Plan. When this health information is provided from the Plan to the Employer or Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI. The provisions of Section 6.2.2 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 or Plan Sponsor'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.

An Employer or Plan Sponsor 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.

6.2.2.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to an Employer or Plan Sponsor 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, employee ID or social security number, contribution history, account balance information, age, employment status (active, retired, separated), limited account status, 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 each Employer and Plan Sponsor acknowledge and agree that enrollment and disenrollment information is information of the Employer or Plan Sponsor and is held on behalf of the Employer or Plan Sponsor by the Plan. Enrollment and disenrollment information held at any time by the Employer or Plan Sponsor is held in its capacity as an Employer or Plan Sponsor and is not PHI.

6.2.2.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to an Employer or Plan Sponsor, provided that the Employer or Plan Sponsor 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.

"*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 or Employer has provided health benefits under the Plan; and (2) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.2.2.4 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 Section 6.2.2.5 and obtaining written certification pursuant to Section 6.2.2.8, the Plan may disclose PHI and Electronic PHI to an Employer or Plan Sponsor, provided that the Employer or Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.2.2.4.1 "*Plan Administration Purposes*" means administration functions performed by the Employer or Plan Sponsor 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 or Plan Sponsor in connection with any other benefit or benefit plan of the Employer or Plan Sponsor or any employment-related actions or decisions.

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

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

6.2.2.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer and the Plan Sponsor agree that with respect to any PHI it receives from the Plan pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.2.2.8 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), such Employer and the Plan Sponsor shall:

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

6.2.2.5.2 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 and the Plan Sponsor with respect to PHI;

6.2.2.5.3 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 or Plan Sponsor;

6.2.2.5.4 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;

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

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

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

6.2.2.5.8 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;

6.2.2.5.9 if feasible, return or destroy all PHI received from the Plan that the Employer or Plan Sponsor 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

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

6.2.2.6 Additional Requirements. Each Employer and the Plan Sponsor further agree 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 Section 6.2.2.8 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 or Plan Sponsor who need the information for Plan Administration Purposes and employees of the Employer or Plan Sponsor who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer or Plan Sponsor, 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 or Plan Sponsor 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 or Plan Sponsor 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.

6.2.2.7 Adequate Separation Between Plan and Employer and Between Employees Who Perform Plan Administration Functions and Employees Who Do Not Have Plan Administration Functions. Any Employer or Plan Sponsor that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.2.2.8 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 or Plan Sponsor'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 or Plan Sponsor 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 or Plan Sponsor for non-compliance pursuant to the Employer's or Plan Sponsor's employee discipline and termination procedures.

The Employer and Plan Sponsor 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.

6.2.2.8 Certification of the Plan Sponsor and Employers. 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 an Employer or Plan Sponsor only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer or Plan Sponsor acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer or Plan Sponsor agrees to the conditions of disclosure set forth in Section 6.2.2 and all other conditions and requirements of this HIPAA Plan Amendment.

6.3 Qualified Medical Child Support Orders and National Medical Support Notices. The Plan shall comply with all applicable rules and laws relating to Qualified Medical Child Support Orders ("QMCSO") and National Medical Support Notices ("NMSN"). In the event a QMCSO or NMSN is received by the Plan, the Plan will follow the policies and procedures for determining and administering such order or notice as the same may be adopted or revised from time to time by the Administrator.

ARTICLE VII.
Administrator

7.1 Rights and Duties. By execution of the Plan Adoption Agreement, the Plan Sponsor authorizes the Administrator to administer the Plan in accordance with its terms and all

rules, policies and procedures established by the Plan as are necessary and appropriate for the administration of the Plan. The delegation of administrative authority to the Administrator shall include the following responsibilities and authority, which the Administrator shall exercise in a uniform manner so that all persons similarly-situated shall be similarly treated:

7.1.1 To determine entitlement to Benefits to the extent set forth under Articles V and VI.

7.1.2 To compute the amount and kind of Benefits payable to or with respect to Participants.

7.1.3 To maintain all the necessary records for the administration of this Plan other than those maintained by the Plan Sponsor or a Participating Employer.

7.1.4 To prepare and file or distribute all reports and notices required by law with respect to the Plan.

7.1.5 To authorize all disbursements from the Plan.

7.1.6 To direct the allocation, investment, reallocation, and redemption of funds within Participant Accounts and Employer Accounts.

7.1.7 To act on behalf of the Plan Sponsor as permitted or required by the Plan, the Plan Adoption Agreement, or as otherwise directed by the Plan Sponsor.

7.1.8 To interpret provisions and the Plan Documents for purposes of administration of the Plan.

7.1.9 To establish or approve such rules, policies and procedures for the funding and administration of this Plan that are not inconsistent with the terms of the Plan Documents.

7.2 **Information**. To enable the Administrator to perform its functions, the Plan Sponsor and Employer shall supply the Administrator and other Plan Representatives with full and timely information on all matters relating to contributions and each Employee's eligibility to participate in the Plan. The Administrator shall maintain such information and advise the Employer or Plan Sponsor of such other information as may be necessary to the administration of the Plan. The Administrator and other Plan Representatives shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action of the Employer for the purpose of performing its duties under the Plan, and the Administrator and other Plan Representatives shall have the right to rely on information provided by the Employer or Plan Sponsor with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action of the Employer.

7.2.1 Within a reasonable amount of time after receipt of a complete

Enrollment File with respect to a Participant, the Plan shall deliver a written acknowledgement to the Participant, acknowledging establishment of the Participant Account or Accounts and confirmation of any contributions received. The information will also include a Summary Plan Description. At the time an Employee becomes Claims-Eligible, the Plan shall provide the Participant with information relating to his or her Participant Account or Accounts and how to request payment of Benefits.

7.2.2 The Plan shall provide to Participants a published statement at regular intervals which shall include the following information: name and address; contributions received and the month the amount was posted to the Participant Account or Accounts; total Participant Account value at statement date; income earned or other gain or loss; all payout and disbursement amounts, and increases or decreases for expenses or benefit payments; ending/forward balance; and contact information for error corrections or questions regarding the statement.

7.3 Delegation of Certain Non-discretionary Duties. In accordance with the terms of the Plan Adoption Agreement, the Plan Sponsor or its designee shall serve as the Administrator for the Plan. Without relieving the Administrator of any of its obligations under the Plan, the Plan Sponsor has engaged the HRA Service Manager to provide ministerial and non-discretionary Plan Administration Support Services as specified herein and in the other Plan Documents or otherwise at the direction of the Plan Sponsor or Administrator. The Plan Sponsor has authorized and directed the HRA Service Manager to assist the Administrator in the performance and execution all of the duties, powers, and responsibilities of the Administrator specifically defined in the Plan Documents, subject to the approval and direction of the Administrator for any such duties, powers, or responsibilities that require the discretion of the Administrator or that are not otherwise specifically prescribed in the Plan Documents, such assistance to include without limitation the specific non-discretionary and ministerial Plan Administration Support Services. Where the Plan Documents or Plan Sponsor specifically direct or authorize the HRA Service Manager to perform a certain function, task, service, or role on behalf of the Plan Administrator, such actions of the HRA Service Manager in fulfilling those obligations shall not be considered discretionary decisions of the HRA Service Manager. Without relieving the HRA Service Manager of its obligations under the Plan Documents, the Plan Sponsor has authorized the HRA Service Manager to designate one or more Plan Representatives as agents or sub-contractors of the HRA Service Manager to carry out any administrative services to be performed by the HRA Service Manager, including one or more third-party service providers for record-keeping, regulatory reporting, customer service, claims and contribution processing services, creation or production of Plan forms, notices, and literature, investment management services, and a custodian/transfer agent to hold the assets of the Plan.

7.4 Compensation of Administrator and Plan Expenses. The Plan Sponsor agrees that the Administrator shall be entitled to compensation as agreed between the Plan Sponsor and the Administrator. The Plan Sponsor also agrees that the HRA Service Manager shall be entitled to compensation payable from Plan assets at the rate of compensation provided for in the Plan Adoption Agreement. The Plan Sponsor hereby authorizes the Administrator (and the HRA Service Manager to the extent it is delegated non-discretionary and ministerial duties and responsibilities of the Administrator) to employ such consultants, investment managers,

administrators, lawyers, accountants, agents, actuaries and other service providers as it reasonably deems necessary or appropriate in carrying out its responsibilities under the Plan Documents, as provided in the Plan Adoption Agreement, and such service providers shall be entitled to reasonable compensation for and reimbursement of expenses relating to such services which may be paid by assessments from Participant Accounts as set forth in the Plan Documents or as otherwise required or permitted by applicable law or mutually determined by the Plan Sponsor and the HRA Service Manager. Additionally, all other reasonable expenses of administration of the Plan, including but not limited to fees and expenses for: legal, benefits staff, third-party administrator, auditing, printing, postage, mail service, plan administration software or technology, bank, trustee, custodian, consultant, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Plan, Participants, the Plan Sponsor, or a Participating Employer may be paid through reasonable fees and assessments from Participant Accounts from time to time, or by the Employer.

7.5 **Resignation and Removal of, and Successors to Administrator, HRA Service Manager, and Other Plan Representatives.** Resignation, removal, and replacement of the Administrator shall be determined according to any rules, policies, procedures, or contractual arrangements between the Plan Sponsor and the Administrator. Resignation, removal, or replacement of the Administrator shall not affect the duties and responsibilities or role of the HRA Service Manager or other Plan Representatives set forth in the HealthInvest HRA Plan Documents. Resignation, removal, and replacement of the HRA Service Manager or other Plan Representatives shall be governed by the terms of the Plan Adoption Agreement. If for any reason a vacancy should occur in the position of the Administrator, the Plan Sponsor may appoint a successor Administrator or succeed as the Administrator until such time as a successor Administrator is appointed by the Plan Sponsor. Unless otherwise agreed by any Administrator, no successor or predecessor Administrator shall be liable for the acts or ommissions of any other Administrator.

7.6 **Discretion and Standard of Review**. The Administrator has full and absolute discretion in the exercise or delegation of each and every aspect of the rights, power, authority and duties relating to the administration of the Plan, including without limitation, the authority to determine all facts, to interpret this Plan, to apply the terms of this Plan to the facts determined, to make decisions based upon those facts and to make any and all other decisions required of it by this Plan, such as the right to Benefits, the correct amount and form of Benefits, the determination of any appeal, the review and correction of the actions of any Plan Representative, and the other rights, powers, authority and duties specified in this paragraph and elsewhere in this Plan. Notwithstanding any provision of law, or any explicit or implicit provision of this document, any action taken, or finding, interpretation, ruling or decision made by the Administrator in the exercise of any of such rights, powers, authority or duties under this Plan shall be final and conclusive as to all parties, including without limitation all Participants, former Participants and Dependents, or any other person entitled to receive Benefits from a Participant Account, regardless of whether the Administrator (or one or more of the members of any Plan administrative committee) may have an actual or potential conflict of interest with respect to the subject matter of the action, finding, interpretation, ruling or decision. No such final action, finding, interpretation, ruling or decision of the Administrator shall be subject to *de novo* review in any judicial proceeding. No such final action, finding, interpretation, ruling or decision of the Administrator may be set aside unless it is

held to have been arbitrary and capricious by a final judgment of a court having jurisdiction with respect to the issue.

ARTICLE VIII.
Amendment and Termination

8.1 Amendments.

8.1.1 Subject to the provisions of the Plan Adoption Agreement and the following paragraphs of this Section 8.1 and Section 8.2 hereof, the Plan Sponsor shall have the right to amend the Plan from time to time, including amendments to its elections under the Plan Adoption Agreement.

8.1.2 Any Plan amendment proposed by the Plan Sponsor must be submitted to the HRA Service Manager, and such amendment shall not take effect until the HRA Service Manager delivers written acceptance of such amendment, subject to the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the Plan Adoption Agreement.

8.1.3 Subject to Section 8.1.4 hereof and the HRA Service Manager's right to resign and the Plan Sponsor's right to remove the HRA Service Manager under the Plan Adoption Agreement, and except as otherwise provided in the Plan Adoption Agreement, the HRA Service Manager shall have the right to amend the provisions of the HealthInvest HRA Plan Coverage Documents from time to time, and to amend or cancel any such amendments to the extent specifically authorized and directed by the Plan Sponsor in the Plan Adoption Agreement. The HRA Service Manager shall deliver to the Plan Sponsor and/or the Administrator notice of any amendment within ninety (90) days after the effective date of such amendment. Notwithstanding the stated effective date of any amendment, such amendment may be current, retroactive, or prospective, in each case as provided therein. If the Plan Sponsor does not submit any objections or proposed amendment to the HRA Service Manager's revisions within thirty (30) days of receipt by the Plan Sponsor and/or Administrator, such revisions are deemed approved by the Plan Sponsor and/or Administrator.

8.1.4 Unless otherwise provided in the Plan Adoption Agreement or applicable Trust Agreement, no amendment to the Plan shall permit any part of the Plan assets, to be used for or diverted to purposes other than for the payment of Benefits under the Plan to Participants, Dependents, and any other person entitled to receive Benefits from a Participant Account and to defray reasonable expenses of administering the Plan, and no amendment may permit amounts credited to a Participant Account to be used to provide Benefits to a person other than the Participant, his or her Dependents, or any other person specifically entitled to receive Benefits from such Participant Account, unless there has been a forfeiture of the balance of such Participant Account.

8.1.5 Any amendment to the Plan required by applicable law shall take effect as required by such applicable law to the extent such requirements are inconsistent with this section.

8.2 Termination/Discontinuance of Contributions/Transfers. No provision of the Plan shall impose any obligation on the Employer or Plan Sponsor to make, or continue making, contributions to the Plan, and, except as it may otherwise be legally obligated, the Employer or Plan Sponsor may discontinue Plan contributions at any time. Except as otherwise provided in the Plan Adoption Agreement, in the event of such a discontinuance of contributions, Plan assets shall continue to be used to provide Benefits in accordance with the terms of the Plan, and any remaining Plan assets will be returned to the Employer or Plan Sponsor upon the satisfaction of all liabilities to provide Benefits under the Plan. Notwithstanding the foregoing, the Plan Sponsor may terminate the Plan, or partially terminate the Plan with respect to any class of Participants, or cause all or an allocable portion of the Plan assets to be transferred to another administration services provider or welfare benefit fund for the benefit of such Participants, provided that: (a) any such transfer does not violate the terms of the Trust Agreement, applicable law, or any legal obligation that the Plan Sponsor or Employer has outside of the terms of the Plan; (b) the Plan Sponsor has provided the HRA Service Manager with a least ninety (90) days' prior notice of such transfer or such shorter time period agreed to in writing by the HRA Service Manager; and (c) the Plan Sponsor has agreed to indemnify and hold harmless the HRA Service Manager and its agents, subcontractors, officers, representatives, and employees from any liability associated with such transfer of assets, and to provide such other consideration to the HRA Service Manager in connection with the transfer as provided for under the Plan Adoption Agreement.

ARTICLE IX.
Miscellaneous

9.1 Applicable Law. This Plan shall be construed, administered, and governed under the laws of the state of domicile of the Plan Sponsor and the applicable federal laws of the United States of America, such federal laws to preempt state law to the extent permitted by applicable state and federal law. If any provision of this Plan shall become or be held to be illegal, invalid, or unenforceable for any reason, such illegality or invalidity shall not affect the remaining portions of this Plan, which shall remain in full force and effect, unless such illegality or invalidity prevents accomplishment of the objectives and purposes of the Plan. In the event of any such holding, the HRA Service Manager may immediately, and if in accordance with law, retroactively, amend the Plan as is necessary to remedy such defect.

APPENDIX A
To Plan Document

Definitions

"Administrator" means the Plan Sponsor or such other person or persons designated in writing as the Administrator in the Plan Adoption Agreement. Some or all of the responsibilities of the Administrator may be carried out by one or more third parties (including the HRA Service Manager or one or more other third-parties to provide enrollment, remittance, claims-adjudication, trustee, custodial, regulatory reporting, and/or record-keeping services) engaged by the Plan Sponsor or the Administrator under the Plan Adoption Agreement or under other trust document or other separate contracts; provided that, such the engagement by the Plan Sponsor of the Administrator, and the engagement by the Plan Sponsor or the Administrator of third-party service providers is not intended to transfer fiduciary responsibility or liability to any person.

"Adverse Benefits Determination" means any denial of a request for Benefits or any rescission or termination of Benefits, in each case in whole or in part, all as more specifically described in the Department of Labor regulations, specifically, 29 C.F.R. §2560.503-7(m)(4). A transaction paid for to a merchant or vendor with the Plan's Health Care Debit Card shall not be considered an Adverse Benefits Determination until such time the Participant receives a communication or notice from the Plan that the transaction is not a Qualified Health Care Expense.

"Benefit Payment Period" means the accounting period for payment to Participants of Benefits that have been approved pursuant to Plan policies and procedures.

"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.

"Card" means the debit/credit card(s) provided by the Administrator and used by Participants for the payment of Benefits under the Plan.

"Card Program" means the procedure and system established by the Administrator utilizing Cards for the payment of Benefits.

"Claimant" has the meaning ascribed to such term in paragraph 6.1.1 hereof.

"Claims Eligibility Date" means, with respect to any Participant Account, the date on or after the Participant Eligibility Date on which a Participant becomes eligible to file claims for expenses incurred on or after such date; provided that reimbursement for any such claims shall be (i) subject to the Plan having first received a complete Enrollment File for such Participant and (ii) limited to the extent that there is a positive account balance in such Participant Account. The Claims Eligibility Date for each account type is specified in the Plan Adoption Agreement.

"Claims-Eligible" means, with respect to one or more Participant Accounts or one or more types of coverage under the Plan, that a Participant has become eligible to file claims for Qualified

Health Care Expenses or Excepted Benefits, as applicable, under the Plan Document governing the eligibility for such Plan coverage under such Participant Account or Accounts.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations promulgated thereunder, as amended from time to time.

"Credited" means, with respect to the timing of a contribution made to a Participant Account, the date on which the Participant who received such contribution earned or became entitled to such contribution pursuant to the terms of this Plan, applicable collective bargaining agreements, Employer policies, or other or other contractual or legal obligations of the Employer.

"Dependent" means a Participant's spouse, dependent (as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), or child (who as of the end of the taxable year has not attained age 27) as determined under IRC §105(b).

"Employee" means any individual that the Employer determines is, or classifies as, a current or former employee of the Employer, including any such person covered by a collective bargaining agreement providing for coverage in the Plan or otherwise based upon the Employer policies or other contractual or legal obligations of the Employer.

"Employer" with respect to any Participant, means the Plan Sponsor (for a single-employer plan) or the Participating Employer (for a multi- or multiple-employer plan) who made or is making contributions on to the HealthInvest HRA Plan on behalf of the Participant.

"Employer Account" refers to an account for the Employer to account for contributions and other Plan assets not allocated to Participant Accounts.

"Employer Participation Agreement" means a Participation Agreement executed by a Participating Employer, pursuant to which the Participating Employer agrees to adopt and participate in the Plan, accepts the terms and conditions of the Plan Adoption Agreement and the the other HealthInvest HRA Plan Documents, and provides information unique to the Participating Employer for the administration of its Plan.

"Enrollment File" means the paper enrollment form, online enrollment information, or enrollment file provided by the Plan Sponsor, Employer or Participant with the information required by the Administrator in order to enroll a Participant in the Plan.

"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)(i)-(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.

"Final Internal Adverse Benefits Determination" means an Adverse Benefits Determination that has been upheld by the Plan at the completion of the internal appeals procedures set forth in Section 6.1.2.

"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) as such term "group health plan" is defined under IRC §§9832(a) and 5000(b)(1) and Treasury Regulation §54.9831-1(a)(1). For purposes of plans subject to ERISA, group health plan shall also have the meaning ascribed under ERISA §3(1) for an employee welfare benefit plan.

"In-service Benefits" means the Benefits and coverage provided under the HealthInvest HRA Plan while a Participant is currently employed by the Employer. The terms and conditions of In-Service Benefits is governed by a separate Plan Document for In-service Benefits Coverage.

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

"IRS" means the Internal Revenue Service.

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

(i) For 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);

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

(iv) For eligibility for limited coverage prior to separation for Participants with Post-separation Accounts (as permitted by the Plan Sponsor's or Employer's plan design elections); and

(v) For eligibility for limited coverage for Dependents who are not integrated with an employer-sponsored group health plan at the time a Qualified Health Care Expense is incurred.

Limited HRA Coverage will be limited to Excepted Benefits only for purposes described in clauses (iii)-(v), 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 Plan Document for Limited HRA Coverage.

"Mandates" means provisions of PPACA known as the "PHSA 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).

"Master Trust" means the master trust created under that certain Declaration of Trust Establishing the HealthInvest HRA Master Trust, effective as of September 1, 2017, established by Washington Trust Bank, as the Master Trustee, as amended, restated, or replaced from time to time.

"Master Trust Adoption Agreement" means that certain Master Trust Adoption Agreement attached as an Addendum to the Plan Adoption Agreement of the Plan Sponsor, among the Master Trustee, the HRA Service Manager, the Plan Sponsor, and the Participating Trust Signatory.

"Master Trustee" means the nondiscretionary, directed trustee, and custodian under the Master Trust.

"Participant" means a current or former Employee who has become a Participant as described in Article II, and whose status as a Participant remains active pursuant to Section 2.2 with respect to at least one Participant Account. However, a Participant shall only become Claims-Eligible as described in Section 2.1.2.

"Participant Account" refers to any account maintained with respect to a Participant to record contributions and adjustments relating thereto and established for the purpose of the payment of Benefits.

"Participant Eligibility Date" unless otherwise specified in writing by the Employer or Plan Sponsor, is the date on which a contribution or an Enrollment File is received by the Plan for a current or former Employee. The Participant Eligibility Date for any Employee may not be earlier than the Plan Effective Date; provided that, for Participants whose plan assets have been transferred by the Plan Sponsor or the Employer from another plan, the Participant Eligibility Date may coincide with each Participant's eligibility date under the prior plan, if designated in writing by the Plan Sponsor or Employer.

"Participating Employer" shall mean a "Participating Employer" named pursuant to an Employer Participation Agreement. References to the term "Participating Employer" used herein shall apply only with respect to multi- or multiple-employer plans. For single-employer plans, provisions applicable to Participating Employers shall have no application.

"Participating Trust" is defined in the Master Trust Adoption Agreement.

"PHI" (or "Protected Health Information") is defined in Section 6.2.2.1.

"Plan Administration Support Services" provided by the HRA Service Manager or any subcontractor of the HRA Service Manager shall include non-discretionary assistance and support for the Administrator in the performance of all duties, powers, and responsibilities of the Administrator specifically set forth in the Plan Documents, policies, or procedures, and other Plan forms and materials (as the same may be amended from time to time) and other non-discretionary duties, powers, and responsibilities approved or directed by the Plan Sponsor from time to time, including without limitation the administration support services described in Appendix B hereof.

"Plan Adoption Agreement" means a Plan Adoption Agreement executed by the Plan Sponsor and accepted by the HRA Service Manager, as the same may be amended, restated, or replaced from time to time, pursuant to which the Plan Sponsor establishes the Plan, identifies the Particpating Employers and Employees eligible to participate in the Plan, and specifies other terms and conditions for the provision of Benefits and administration of the Plan. The terms and provisions of the Plan Adoption Agreement, contributions and disbursements pursuant thereto, and any changes thereto, are all subject to the rules, policies and procedures set forth in the Plan Documents or in Plan forms, policies, and procedures approved by the Plan Sponsor and the HRA Service Manager prior to adoption of the Plan, or as otherwise approved or established by the Administrator pursuant to the direction and authorization of the Employer in the Plan Adoption Agreement. With respect to any Participating Employer, the term "Plan Adoption Agreement" shall include the Employer Participation Agreement of the Employer, which by its terms incorporates the terms of and becomes a part of the Plan Adoption Agreement for purposes of the Participating Employer's Plan.

"Plan Coverage Document" shall mean this Plan Coverage Document and any other plan coverage document governing the terms and conditions of various types of HRA plan coverage included in the HealthInvest HRA Plan.

"Plan Document or HealthInvest HRA Plan Document" is defined in Section 1.2.

"Plan Effective Date" for this Plan shall have the meaning set forth for such term or the term "Plan Effective Date" in the Plan Adoption Agreement, notwithstanding that the Plan and Plan Documents may be amended, restated, or replaced from time to time.

"Plan Representative" shall mean any service provider or other third party appointed by the Plan Sponsor or Administrator to perform services or otherwise act on behalf of the Administrator, including the HRA Service Manager, and any trustee, custodian, or investment manager and any subcontractor of any of the above as permitted under the Plan Documents.

"Plan Sponsor" shall be the "Plan Sponsor" named in the Plan Adoption Agreement.

"Plan Year" shall, for regulatory reporting purposes, coincide with a regular calendar year. The first Plan Year (which may be a partial Plan Year) is the period from the Effective Date through last date of the Plan Year that includes the Effective Date.

"Post-separation Benefits" means the Benefits and coverage provided under the HealthInvest HRA Plan after a Participant is retired or otherwise separated from service from the

Employer pursuant to the terms and conditions of this Plan Document for Post-separation Benefits Coverage.

"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.

"Premium Reimbursements" means premium reimbursements for out-of-pocket, after-tax payments made to insurance companies, health maintenance organizations, health plans, preferred provider organizations, qualified long-term care insurers, any part of Medicare, or to the Employer for COBRA premium payments.

"Protected Health Information" is defined under the term "PHI."

"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 who last made or caused contributions to be made into such Participant's Participant Account, that such Participant has become re-employed with such Employer (whether or not such re-employment is on a full-time, part-time, or temporary basis) under circumstances that would constitute a traditional employment relationship under customary employment standards and policies. Whether or not a Participant is "Re-employed" for purposes of Claims-Eligibility shall be subject to applicable law and rules, policies and procedures of the Employer.

"Spouse" means, with respect to any Participant, the person to whom the Participant is legally married under any jurisdiction or the person with whom the Participant has otherwise met the legal requirements to establish a domestic partnership if the Participant resides in a jurisdiction where the legal status of a domestic partnership is the same as that of a legal spouse.

"Summary Plan Description" means a written document that (1) summarizes the terms and conditions of the Plan, (2) informs participants, dependents, and other beneficiaries of Plan of their rights, benefits, and responsibilities under and with respect to the Plan, and (3) includes other information that is determined by the Administrator to be important, informational, or required by applicable law.

"Trust" means, if a trust is established at the election of the Plan Sponsor, any such trust established pursuant to the Trust Agreement and that becomes a Participating Trust as defined under the Master Trust.

"Trust Agreement" means the Plan Sponsor Trust agreement or other trust document attached to the Plan Adoption Agreement into which assets for the Plan are funded and held through the custodial account established by the Plan Sponsor under the Plan Adoption Agreement and that becomes a Participating Trust as defined under the Master Trust.

"Valuation Period" means the period for determining investment values for Accounts and shall be no less frequently than monthly.

"Wrap Document(s)" means any written plan document, summary plan description, summary of material modification, or other controlling document, as applicable, of the Plan Sponsor that is intended to wrap around and integrate this HealthInvest HRA Plan, for purposes of outlining Plan eligibility or other rules, and that is incorporated herein as a governing Plan Document for purposes of administering and adopting the HealthInvest HRA, as the same may be amended from time to time.

APPENDIX B
To Plan Document

Plan Administration Support Services

Plan Administration Support Services that may be provided by the HRA Service Manager or any subcontractor of the HRA Service Manager shall include non-discretionary assistance and support for the Administrator in the performance of all duties, powers, and responsibilities of the Administrator specifically set forth in the Plan Documents, policies, or procedures, and other Plan forms and materials and other non-discretionary duties powers, and responsibilities approved or directed by the Plan Sponsor from time to time, including without limitation the following administration support services:

1. Provide assistance to Plan Sponsor and Participating Employers with Plan design elections and completion of plan adoption documents.
2. Provide Plan Sponsor and Participating Employers with Plan adoption/welcome package after receipt of a completed adoption agreement in good order.
3. Design and print Plan literature (including, but not limited to, enrollment forms, claim forms, Investment allocation forms, question-and-answer forms, Plan Summary/Summary Plan Description, etc.).
4. Maintain an inventory of necessary forms and literature
5. Draft, create, and make any changes to Plan documents, Plan forms, Plan materials, Plan literature, and Plan policies and procedures as are routine, desirable, or necessary to improve the efficiency and effectiveness of the operation of the Plan, clarify ambiguities for the benefit of the Administrator, Plan Sponsor, or Eligible Participants, and to comply with applicable legal requirements.
6. Assist with communication between, and coordinate the activities of, all subcontractors and service providers to the Plan.
7. Facilitate payment of operating expenses of the Plan in accordance with the Plan Documents and direction of the Administrator.
8. Provide reasonable assistance and services necessary to obtain or make all necessary regulatory or other governmental filings, registrations and approvals for this Plan, including providing the following information and reports to the Plan Sponsor and Participating Employers:

    - Quarterly fund activity summary – Covers contributions, investment earnings, and distributions for all participating employees on an aggregate basis;
    - Quarterly and annual trust statements – Includes balance sheets, as well as income and expense statements;
    - Disbursement Report – Quarterly report containing aggregate claims paid by category: medical, dental, vision, prescriptions and premiums;

- Other reports – The third-party administration service provider will provide other reports that are reasonable and customary, including transaction reports confirming contributions.

9. Maintain and provide access to all records of the custodian, the HRA Service Manager and others relative to the Plan as needed for Plan and Trust audits.
10. Provide recordkeeping services for Participant and Employer Accounts.
11. Provide ministerial claims reimbursement services to Participants and Employers (for Employer Accounts). Claims reimbursement services include determination if a receipt is valid and covers a qualified expense under IRC §213(d), and delivery of all applicable notices required in the Plan document. Any determination on appeal requiring discretion must be approved in writing by the Administrator.
12. Provide customer service and assistance to Participants regarding education and enrollment, Plan benefits, investment allocations, website and other Plan questions and assistance.
13. Provide technical, compliance, and educational support to the Plan Sponsor and Participating Employers and Eligible Participants.
14. Draft periodic Plan Sponsor/Participating Employer and Participant communications regarding legal and compliance updates, participant rights and responsibilities, and reminders regarding Plan benefits, policies, and procedures, etc.
15. Prepare and deliver notices and documents to Participants and Plan Sponsor/Participating Employers, as necessary, desirable, or required by law, including, but not limited to, communications contemplated for in the Investment Management Services described in Exhibit D, or as otherwise agreed.
16. Recommend and implement operational and compliance policies and procedures for the effective and efficient and compliant operation of the Plan.
17. Provide custodian and transfer agent services with respect to all Plan assets.
18. Assist with the investigation of errors reported to the Plan by a Plan Sponsor, Employer, or Participant.

Attachment G

Gallagher | HealthInvest HRA Summary Plan Description

Attachment G

Gallagher | HealthInvest HRA Summary Plan Description

Gallagher | HealthInvest HRA

Summary Plan Description

Welcome

You are an eligible participant in the HealthInvest Health Reimbursement Arrangement (HRA) plan. Please carefully review this Summary Plan Description (SPD) regarding your HRA account and keep it in a safe place for future reference.

Your employer or plan sponsor may not have elected to include all of the benefits or plan features described in this SPD. Your welcome packet for each HRA account established for you confirms benefits eligibility and any limitations. You may also login online at healthinvesthra.com if you have questions about which benefits and plan features are included in your Plan.

This SPD is intended to provide a summary of the Plan's benefits and the rules that apply regarding the availability of your HRA benefits. For some plans governed by ERISA, additional information regarding eligibility and benefits may be contained in a wrap SPD, the form and content of which is determined by the plan sponsor for your Plan. In the event of a discrepancy or conflict between any wrap SPD, this SPD, any wrap plan document, or the HealthInvest HRA Plan document for your Plan, the wrap plan document will control, and if there is no wrap plan document, the applicable HealthInvest HRA Plan coverage document will control. This SPD will be amended from time to time. For the most current version of this SPD and any wrap SPD, please log in at **healthinvesthra.com** and click **Resources** on the menu bar, or contact our Customer Care Center at 1-844-342-5505 or customercare@healthinvesthra.com.

For any HRA account established for you, you will receive a **welcome packet** after you have been enrolled. This packet will include an **HRA Dashboard** with important Plan and account information, your coverage type, claims-eligibility, and whether your Plan is subject to the Employee Retirement Income Security Act (ERISA) and its regulations under federal law. The plan sponsor identified in your welcome packet will serve as the plan administrator for your Plan. Your plan sponsor will notify you if any wrap SPD or wrap plan document applies. If you misplace your welcome packet, you may request a replacement copy from our Customer Care Center.

HealthInvest HRA is not responsible for the content or timely delivery of any wrap SPD applicable for your Plan. Any wrap SPD applicable for your Plan, as provided to HealthInvest HRA by your plan sponsor, is available after logging in online. For more information see **Important Information for ERISA Plans** under Part I of this SPD.

The most current HealthInvest HRA SPD supersedes any previously published Plan information materials.

By participating in the HealthInvest HRA Plan, you agree to the Terms and Conditions set forth within this SPD under Part XI.

Questions?

1-844-342-5505
customercare@healthinvesthra.com
healthinvesthra.com

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Customer Care Center

1-844-342-5505

customercare@healthinvesthra.com

P.O. Box 80967 Seattle, WA 98108

Fax (206) 686-1402

www.healthinvesthra.com

Part I
Plan information

The name of the Plan is the HealthInvest HRA Plan ("Plan"). The assets of the Plan are held in a custodial account and master trust established by Washington Trust Bank, who serves as the HealthInvest HRA Master Trustee, a non- discretionary, directed trustee. Plan administration support services, including claims processing, are provided by Gallagher Benefit Services, Inc., the HealthInvest HRA Service Manager, or its designees, at the direction of the plan administrator. The plan sponsor identified in your welcome packet is the plan administrator for your plan. There may be one or more additional trustees serving as fiduciaries for your Plan. Contact your plan sponsor for more information.

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

HealthInvest HRA Service Manager
Attn: Gallagher Benefit Services, Inc.
902 West 2nd Ave., Suite 400
Spokane, WA 99201

Service of legal process may be made to the HealthInvest HRA Service Manager or the HealthInvest Master Trustee, at the addresses listed above, or to your plan sponsor/plan administrator at the address included in your welcome packet.

This Plan is a welfare benefit plan that provides medical benefits only and not retirement income or a deferral of income. The medical reimbursement benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf. Accordingly, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

Eligibility and funding sources are usually defined in writing within wrap plan documents, wrap SPDs, collective bargaining agreements, employer policies, or other similar documentation. You should check with your employer, union, or employee group leadership if you have questions about your HRA participation or to obtain a copy of the collective bargaining agreement or employer policy.

The Plan year is the 12-month period from January 1 through December 31.

Requests for benefits under the Plan must be made in writing to the Plan in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing to the Plan.

Important Information for ERISA Plans.

Non-governmental plans may be subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If your welcome packet states that your Plan is subject to ERISA: Refer to Appendix B (ERISA Supplement) containing additional information regarding your Plan and your rights under the Plan as required by ERISA. You may also receive a Summary of Material Modifications (SMM) from time to time, which is required by ERISA to provide you with timely notice of certain material changes to the Plan or information required to be included in this SPD or any wrap SPD. You may obtain a copy of the most current version of this SPD and any SMMs applicable to this SPD, and any wrap SPD and SMMs provided by your plan sponsor, by logging into your account at **healthinvesthra.com** and clicking **Resources. You should read this SPD (as updated from time to time), any SMMs, any wrap SPD, your welcome packet, and Appendix B, together to fully understand your benefits and your rights under the HealthInvest HRA Plan.**

Unless otherwise indicated in your welcome packet or in an ERISA SPD Supplement, your employer is the plan sponsor and the plan administrator for your Plan. The plan administrator has the right to interpret the provisions of this Plan, and make decisions on behalf of the Plan. Benefits under this Plan will be paid only when the plan administrator decides, in its discretion, that the participant or covered individual is entitled to benefits in accordance with the terms of the Plan. In the event a claim for benefits has been denied, no lawsuit or other action against the Plan may be filed until the matter has been submitted for review under the ERISA-mandated review procedures in Part III of this Summary Plan Description. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

Part II
Questions and answers

What is the HealthInvest HRA Plan?

The HealthInvest HRA Plan is a funded health reimbursement arrangement (HRA).

What is an HRA?

An HRA or health reimbursement arrangement is a type of welfare benefit plan or group health plan. An HRA is generally funded by the employer (or through mandatory group funding) and reimburses employees (participants) for qualified out-of-pocket medical care expenses and insurance premiums incurred by the employee, the employee's spouse, and qualified dependents. To understand who qualifies as a dependent, see **Appendix A** for our **Definition of Dependent** information.

What is a funded HRA?

A funded HRA is designed so that your employer contributes funds in to an individual account on your behalf.

Common funding methods include unused leave cash-outs (annually, at separation, or retirement), mandatory employee contributions (group salary reduction), direct employer contributions, and excess or leftover benefit dollars. Eligibility and funding sources, including any changes in funding, are usually defined in writing within collective bargaining agreements, employer policies, or similar documentation. You should check with your plan sponsor, employer, union, or employee group leadership if you have questions about what HRA funding sources may apply to you.

Your plan sponsor may have established a trust for the safekeeping of your HRA funds. Funds for all plans and trusts participating in the HealthInvest HRA program are contributed to a custodial account and master trust established by Washington Trust Bank, who serves as the HealthInvest HRA Master Trustee, a non-discretionary, directed trustee.

All contributions, investment earnings, and reimbursements (benefit payments) are tax-free. Contributions to your HealthInvest HRA account are not subject to federal income tax or FICA tax. Investment earnings credited to your HealthInvest HRA account are not subject to federal income tax.

Reimbursements paid out as qualified medical expenses on behalf of participants, spouses, and qualified dependents are also excluded from tax. HRA contributions will not be reported on IRS Form W-2 from your employer. You do not report HRA contributions, earnings, or benefit payments (reimbursements) on your individual IRS Form 1040 federal income tax return either.

Who is the plan sponsor for my Plan?

That depends on your plan sponsor's plan design elections and whether your Plan is a single-employer plan or is established for more than one contributing employer. For most single-employer plans, the employer is the plan sponsor and plan administrator for the plan. For plans established for more than one contributing employer, the plan sponsor may be a board, committee, association, or third-party other than your employer. Unless otherwise indicated in your **welcome packet** or in an **ERISA SPD Supplement**, your employer is the plan sponsor and the plan administrator for your Plan.

What type(s) of benefits coverage do I have?

Based upon current guidance issued under federal law, the HealthInvest HRA offers three different types of benefits coverage: **In-service Benefits coverage, Post-separation Benefits coverage,** and **Limited HRA coverage**. Each of these plan coverages is designed to be exempt from the annual and lifetime dollar-limit restrictions for group health plans. This means that your benefits under the Plan are limited by your account balance at the time you file any claim for reimbursement of qualified medical care expenses.

Some employers or plan sponsors may establish and contribute funds on your behalf to more than one HRA account, and each account may provide a different coverage type.

For any HRA account established for you, you will receive a **welcome packet** that confirms your benefits coverage type at the time of enrollment.

However, your coverage could change based upon restrictions under applicable law or coverage election changes that you make. You can always login at **healthinvesthra.com** to confirm current your benefits coverage for each account.

What is In-service Benefits coverage?

In-service Benefits coverage is designed to be "integrated" with each employer's qualified group health plan that complies with certain requirements under federal law. Under the terms of the In-service Benefits Plan document, a participant's HRA account is considered integrated with the employer's qualified group health plan and eligible to receive employer contributions only if, at the time the participant becomes eligible for such contribution, the participant is eligible to enroll in his or her employer's qualified group health plan and either (a) is actually enrolled in or covered by the employer's qualified group health plan or (b) has provided written confirmation of enrollment in or coverage under another qualified group health plan. Read the **What is a Qualified Group Health Plan?** handout to learn more. To get a copy, log in at **healthinvesthra.com** and click **Resources**, or contact our Customer Care Center at customercare@healthinvesthra.com or 1-844-342-5505.

Please note that HRA accounts of participants who are offered coverage through the purchase of individual policies (as opposed to employer-sponsored group coverage) are not considered integrated with the employer's qualified group health plan and are not eligible to receive contributions to an account that allows In-service Benefits.

What is Post-separation Benefits coverage?

Post-separation Benefits coverage is designed to provide benefits only after a participant separates from service or retires. Post-separation (retiree-only) HRAs are not subject to the annual and lifetime limits restrictions and certain other provisions of federal law. The HealthInvest HRA Plan can accept contributions into an account limited to Post-separation Benefits on behalf of any eligible employee, including those who are not eligible to receive contributions to an In-service Benefits account.

What is Limited HRA coverage?

Limited HRA coverage is designed to provide limited forms of benefit coverage based upon plan design elections by your plan sponsor, restrictions governed by federal law, or certain elections made by you as further described below. For information about Limited HRA coverage based upon plan design or restrictions governed by federal law, read **Are there any restrictions?** below. For more information about Limited HRA coverage based upon elections made by you, read **What is Limited HRA coverage, and why might I need it?** below.

Where can I find the forms I will need for my HRA plan?

All the HRA forms that you will need in order to file claims, change investment allocations, change personal information, and make other elections can be obtained by logging into your account online at **healthinvesthra.com** or from our Customer Care Center upon request.

When and how can I get money out of my HRA account?

Your eligibility to file claims depends on plan design elections by your plan sponsor. For HRA accounts that allow In-service Benefits, employees may file claims while they are currently employed (in-service), for expenses they incur after they are enrolled. HRA accounts limited to Post-separation Benefits require employees to separate from service or retire (and, in some cases, satisfy employer vesting requirements) before becoming eligible to file claims for expenses incurred after separation from service.

For any HRA account established for you, you can confirm your claims eligibility and any vesting requirements by referencing your **welcome packet** or by logging in at **healthinvesthra.com**. If you are not immediately eligible to file claims, you will be notified when you do become eligible.

After becoming claims-eligible, and depending on the eligibility terms of your HRA account, you may begin filing claims for qualified out-of- pocket medical care expenses incurred by you, your spouse, and any qualified dependents.

You may file claims for any amount, but reimbursements are limited to your available HRA account balance. Eligible benefits will be paid until your HRA account is exhausted. Your employer's plan design, IRS rules, or certain elections made by you may limit dependent coverage, as well as when and what expenses may be reimbursed

Claims payment is efficient and hassle-free. To expedite the process, you may sign up for direct deposit instead of waiting to receive paper check reimbursements in the mail. Automatic reimbursement of recurring qualified insurance premiums is also available.

Participant forms, including **Claim Forms, Direct Deposit Enrollment Forms**, and **Automatic Premium Reimbursement Forms**, are all available online after logging in to your account at **healthinvesthra.com** or upon request from our Customer Care Center.

What expenses are eligible for reimbursement?

Eligible expenses generally include qualified medical, dental, and vision expenses (not covered by your insurance plans) and premiums for medical, dental, or vision, insurance or for Medicare premiums and expenses, and tax-qualified long-term care insurance. To be eligible for reimbursement, over-the-counter (OTC) medicines and drugs (except insulin and contact lens solution) must be prescribed by a medical professional or accompanied by a note from

a medical practitioner recommending the item or service to treat a specific medical condition. Eligible expenses are defined in Internal Revenue Code § 213(d). A list of common **qualified expenses and premiums** is available after logging in to your account at **healthinvesthra.com** or upon request from our Customer Care Center.

IRS regulations provide that insurance premiums may not be reimbursed by your Plan if they are (1) paid by an employer, (2) eligible to be deducted through your employer's Section 125 cafeteria plan, or (3) subsidized by the Premium Tax Credit. When requesting reimbursement of premiums deducted from your paycheck after tax, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available to you. Qualified premiums deducted from your spouse's paycheck after tax are eligible for reimbursement regardless of whether a pre-tax option exists for your spouse.

Qualified expenses that may be reimbursed from your HRA for you and your dependents will depend on the plan design elections for each HRA account established for you, IRS rules, or certain elections you may make to limit your HRA coverage. For example, some plan designs limit reimbursements to qualified insurance premiums only. Under certain circumstances (discussed later in this Section), expenses for your spouse and dependents may be limited based upon rules imposed under federal law. Also, if you have elected limited HRA coverage (discussed later in this section), the types of expenses eligible for reimbursement are limited.

Are there any restrictions?

Reimbursements (claims) may never exceed your available account balance at the time you file the claim. Depending on the plan design for any HRA account established for you, your account may be subject to vesting requirements or be limited to Post-separation Benefits coverage. Also, some employers or plan sponsors limit reimbursements to qualified insurance premiums only.

Some employers or plan sponsors may establish and contribute funds on your behalf to more than one type of HRA account, and each account may be subject to different limitations as further described in this Section.

Your **welcome packet** for each HRA account established for you confirms your benefits eligibility and any restrictions on your account. You may also login at **healthinvesthra.com** to confirm whether your Plan has any limitations on reimbursable expenses.

If your plan sponsor has established an HRA account for you that is limited to Post-separation Benefits coverage, IRS rules require that your claims eligibility be limited to reimbursement of expenses and premiums for dental, vision, and qualified long-term care ("Excepted Benefits") during any period that you are subsequently re-employed with the employer that made contributions to your HRA account. For some Post-separation Benefits plans, the plan design for your HRA account may permit reimbursement for Excepted Benefits during active employment, while other employer Post-separation Benefits plans may not.

If you have an In-service Benefits HRA account (meaning your account permits In-service Benefits coverage), spouse and dependent integration rules issued under federal law will apply. This means that certain expenses for your spouse and dependents may not be reimbursable while you are employed, unless your spouse and dependents are covered under a group health plan (GHP) at the time the expense is incurred. The spouse and dependent integration rules **only** apply if you are still working for the employer who contributed to your account.

You can confirm GHP coverage for your spouse or dependent(s) on your claim form when you submit a claim. If your spouse or dependent(s) are not covered by a GHP, you can still use your HRA to reimburse you for their:

- Dental expenses and premiums;
- Vision expenses and premiums; and
- Tax-qualified long-term care expenses and premiums.

Can my HRA account automatically reimburse my insurance premiums?

Yes. Simply submit a completed and signed **Automatic Premium Reimbursement** form with proper documentation. Based on your instructions, the Plan will reimburse insurance premiums from your account on an automatic basis. Direct deposit of reimbursements is available and recommended.

What happens if my claim for reimbursement is denied or paid in error?

If your claim for reimbursement of expenses is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims are discussed in Part III of this document or in any applicable wrap SPD.

If after receiving a reimbursement it is later determined that you, your spouse, or a qualified dependent received a payment in error, federal regulations require that you repay the overpayment or erroneous reimbursement back to your HealthInvest HRA account. If you do not repay the overpayment or erroneous payment, the HealthInvest HRA Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment against your account.

What is limited HRA coverage, and why might I need it?

Limited HRA coverage is an election that limits the types of expenses and premiums that are eligible for reimbursement from your HRA. If you are claims eligible, you may want to limit your HealthInvest HRA account if:

1. You are a current employee and you, your spouse, or a dependent have Medicare coverage that you want to be primary to your HRA coverage;
2. You, your spouse, or a dependent would like to be eligible to make or receive contributions to a health savings account (HSA); or
3. You, your spouse, or a dependent want to become eligible to receive a Premium Tax Credit through a marketplace exchange.

HSA coordination. IRS rules allow you to have an HRA and an HSA, though certain restrictions apply. If you are claims-eligible, you can use either your HRA or HSA to reimburse your qualified expenses (there are no ordering rules regarding which account must pay first). However, if you have a claims-eligible HRA account, current IRS rules require that you limit that HRA coverage if you want to make or receive contributions to an HSA. Keep in mind that limiting your HRA account is not the only HSA contribution eligibility requirement.

Only the following types of expenses and premiums are eligible for reimbursement while your HRA account is limited for HSA coordination purposes:

- Dental (including orthodontia)
- Qualified high-deductible health plan (HDHP) premiums
- Vision

Medicare coordination. If you have a claims-eligible HRA account and are still working for your contributing employer, Medicare Coordination of Benefits rules may require your HRA pay first. If you are retired or separated from your HRA contributing employer, the Medicare Coordination of Benefits rules will **not** apply to your HRA account. Read Part VI for more information about your HealthInvest HRA account and Medicare. If Medicare Coordination of Benefits rules do apply to your HRA account, you may limit your HRA account until you separate from service so that Medicare instead pays first.

Only the following types of expenses and premiums are eligible for reimbursement while your HRA account is limited for Medicare coordination purposes:

- Dental (including orthodontia)
- Vision
- Medicare and Medicare supplement premiums

Premium Tax Credit eligibility. For any month that you are claims-eligible and have a positive account balance in any HRA account, you may not qualify for the Premium Tax Credit unless you take certain action. Please refer to Part V for more information.

Only the following types of expenses and premiums are eligible for reimbursement while your HRA account is limited for Premium Tax Credit eligibility purposes:

- Dental (including orthodontia)
- Qualified long-term care (subject to IRS limits)
- Vision

To elect limited HRA coverage, simply submit a completed **Limited HRA Coverage Election** form. Forms are available online after logging in to your account at **healthinvesthra.com** or from our Customer Care Center upon request. If you have any questions, please contact our Customer Care Center.

What happens if I get divorced?

In the event that you become divorced or legally separated, your account may be split as part of a divorce decree, court order, or similar agreement. Coverage for an ex-spouse is taxable. Contact the Customer Care Center for more information.

What if I pass away before I use up my HRA account?

Generally, if you pass away with a vested, positive account balance and you are survived by a spouse or qualified dependents who are covered under your HRA plan, your spouse (which may include registered domestic partners, if recognized as legal spouses under state law) and/or dependents (or their guardians) may submit claims for medical expense reimbursements until your account is exhausted. In the unlikely event you pass away with an unused account balance and have no eligible survivors, the executor of your estate can spend down your account by filing claims for any unreimbursed medical care expenses you may have incurred prior to your death.

Remaining funds (if any) after all final claims have been reimbursed would then be forfeited and re-contributed per the terms of your plan sponsor's HealthInvest HRA Plan document or otherwise applied as directed by your plan sponsor. As a general rule, IRS rules do not permit the payment of benefits to non-dependent heirs or beneficiaries under your Plan.

In certain circumstances, your HRA may qualify for additional (or extended) survivor benefits available to and elected by certain governmental plans. Whether your HRA qualifies depends on a narrow exception under the applicable law and your plan sponsor's trust and plan design. If the expanded survivor benefit applies, you will find a **Survivor Benefit Elections** packet with more information online after logging in at **healthinvesthra.com** and clicking **Resources**.

Are there any other forfeiture provisions?

Yes, a claims-eligible HRA account may be forfeited and redistributed according to instructions from your plan sponsor. A forfeiture would apply if, during a period equal to the lessor of the applicable unclaimed property period or three years: (1) at least two communications from the Plan to the participant have been returned as undeliverable; (2) there have been no contributions to or reimbursements (claims) from the participant account; and (3) no communications or other expressions of interest have been received from or on behalf of the participant.

Is my HRA account vested?

That depends upon your employer's policy or collective bargaining agreement, whichever is applicable. Some HRA accounts limited to Post-separation Benefits may be subject to vesting requirements of your employer. Your **welcome packet** for each HRA account established for you confirms whether vesting requirements apply to your account. You can also check with your employer or plan sponsor to confirm whether one or more of your HRA accounts are subject to vesting.

For any HRA account that are subject to vesting, your employer or plan sponsor will notify the Plan when you separate from service and confirm whether you are partially or fully vested. The Plan will then notify you of your vested amount that is available to reimburse claims for qualified expenses.

How are my HRA funds invested?

You may invest your HRA account using any combination of the available investment funds. You may change your investment allocations as often as once per calendar month after logging in to your account online at **healthinvesthra.com** or by calling our Customer Care Center.

An **Investment Fund Overview** with investment performance history and fund objectives is updated quarterly and available after logging you're your account online at **healthinvesthra.com**. In addition, you may view up-to-date fund fact sheets and prospectuses on the fund websites, which are listed on the Investment Fund Overview.

Will I receive a statement of my HRA account?

Yes. Participant account statements, which detail all of your account activity, are updated quarterly and available for viewing online after logging in at **healthinvesthra.com**. If you are signed up for e-communication, you will receive quarterly email notifications as soon as your statements are available for online viewing. If you are not signed up for e-communication, paper statements will be mailed annually to your address on file. You may contact our Customer Care Center to request copies of your statements at any time.

Can I view my HRA account information online?

Yes. You may view your personal account information online after logging in to your account at **healthinvesthra.com**. Information available online includes account details and preferences, investment performance, contribution and claims history, and participant forms. You can also set up an automatic premium reimbursement, update account preferences, and update your personal information (name, address, etc.).

Are any fees or expenses deducted from my HRA account?

Plan expenses include costs for plan administration services, including enrollment and claims processing, plan management, recordkeeping, legal, compliance, printing, banking and custodial, web management, investment management, postage, etc. These Plan

expenses are paid from Plan administrative fees. Fee structures vary by plan sponsor, and usually include a flat monthly account fee and/or an annualized asset-based fee deducted from your account or paid by your employer or plan sponsor. Fees that are deducted from your account are listed on your account statements under **Important Notes**. It is possible that these fees could exceed your investment return. Investment fund manager fees and other fund expenses are based on the investment fund(s) you select. To view these fees, refer to the **Investment Fund Overview** for your employer's plan. You can get a list of fees applicable to your Plan and a copy of the Investment Fund Overview online after logging in at **healthinvesthra.com** and clicking **Resources**.

Will the Plan always be available?

Your plan sponsor retains the right to discontinue your Plan subject to the provisions of collective bargaining (if applicable), ERISA, and in accordance with the terms of your Plan's trust instrument. If the Plan were to be discontinued, Plan assets would be treated in accordance with the terms of the Plan document and the terms of your Plan's trust instrument.

Part III
Procedure for disputed claims

The following is an overview of how you may dispute denied claims. These procedures shall apply unless disputed claims procedures are otherwise provided for in a wrap SPD. Be sure to read this HealthInvest SPD and any wrap SPD together to understand how to address any disputed claims.

If you have a question or complaint regarding how one of your claims was adjudicated, please reach out to our Customer Care Center. A Customer Service Representative is happy to look into your claim and address your questions or concerns. Our Customer Care Center is often able to help resolve the matter and alleviate any frustrations.

When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Plan's receipt of the claim. The 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Plan. The Plan is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Plan will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you submit the additional information, the Plan will notify you of the decision on your claim within 15 days after the date of receipt of such information. If you do not submit the additional information, the claim will be deemed to be denied immediately following such 45-day period. The notice from the Plan requesting additional information may also contain a provisional denial of the claim in the event the additional information is not received within the 45-day period.

What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Plan will include the following information:

- The specific reason or reasons for the denial and sufficient information to identify the claim involved, if any, including the date of service, the healthcare provider, and the claim amount (if applicable);
- Specific references to pertinent plan provisions or IRS rules and regulations on which the denial is based;

- An explanation of your right to appeal the denial;
- A description of any additional material or information necessary for you to perfect the claim or appeal the denial and an explanation of why such material or information is necessary;
- An explanation of your right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process;
- A description of available internal appeals procedures, including information regarding how to request an internal review of your denial and the time frame within which to submit such a request;
- An explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

If you do not receive an approval or denial of your claim within the initial time period for review of your claim, your claim will be deemed to have been denied.

Do I have the right to appeal a denied claim?

Yes, you have the right to an internal appeal and, if applicable, an external review by an independent review organization.

Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, your employer or plan sponsor, the administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit, and a final external review decision does not prevent you from pursuing other state or federal law remedies if they are available.

Is there a deadline for requesting my internal appeal?

Yes. Your internal appeal must be delivered to the Plan within 180 days from the date you receive notice that your claim was denied or from the date your claim was deemed to be denied. If you do not file your internal appeal within this 180-day period, you lose your right to appeal.

How will my internal appeal be reviewed?

Any time before the deadline to request an internal appeal, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Plan. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Plan will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Plan relies on, generates, or considers new or additional evidence in connection with its final internal adverse benefit determination, other than evidence that you have provided to it, you will be provided with this information within 30 days after the date the Plan received your request for internal appeal, and given a reasonable opportunity (15 days) to respond to the evidence or rationale before the due date for the Plan's internal review decision. If you do not respond to the new or additional evidence or rationale considered in denying your claim within the time period permitted to respond, your claim will be deemed to have received a final internal adverse benefit determination immediately following such time period. The notice from the Plan with such additional evidence or rationale may also contain a provisional final internal adverse claim determination in the event the additional information is not received within the specified time period.

The internal appeal determination will be conducted by someone who is not (1) the individual who made the original determination; or (2) an individual who is a subordinate of the individual who made the initial determination.

When will I be notified of the decision on my internal appeal?

The Plan must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

What information is included in the notice of the denial of my internal appeal?

If you receive a final internal adverse benefit determination, the notice that you receive from the Plan will include the following information:

- The specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the healthcare provider, and the claim amount (if applicable);
- Specific references to the pertinent plan provisions or IRS rules and regulations on which the decision is based;
- A description of available external review procedures, including information regarding how to request an external review of the internal appeals decision and the time frame within which to submit such a request; and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist you with the external review procedures.

If you do not receive an approval or denial of your appeal within the initial time period for review of your appeal, your appeal will be deemed to have received a final internal adverse benefit determination subject to external review.

Do I have the right to seek a review of a final internal adverse claim determination to an external third party?

You have the right to an external review of the Plan's denial of your internal appeal, unless the denial was based on your (or your spouse's or dependent's) failure to meet the Plan's eligibility requirements.

Is there a deadline for filing my request for external review?

Yes. You must file your request for external review not later than the first day of the fifth month after you received notice from the Plan of, or are deemed to receive, a final internal adverse benefit determination. If you do not file your request for external review within this period, you lose your right to external appeal. For example, if you received or are deemed to receive your final internal adverse benefit determination on January 3 of any year, you must request external review by June 1 of the same year (or, if that is not a business day, the next business day thereafter).

What is the process for my external appeal?

Within five business days after receiving the external review request, the Plan must complete a preliminary review to determine if:

- You are covered under the Plan;
- You provided all the information and forms necessary to process the external review;
- You followed and exhausted the internal appeals procedures; and
- The denial of your claim related to you (or your spouse or dependent) not meeting the eligibility requirements under the Plan, as claim denials based upon a failure to meet eligibility requirements are not subject to external review.

Within one business day after completion of its preliminary review, the Plan will provide you with written notice of the outcome of its review. If your request for external review is complete but the claim denial is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and you will be permitted to complete the request not later than the deadline for filing a request for external review, or 48 hours after your receipt of the Plan's preliminary review notice, whichever is later.

If the Plan receives a timely, completed, and eligible request for external review, the Plan will assign an independent review organization (IRO) to review the claim and you will receive written notice from the IRO that your request is eligible for external review and has been assigned to such IRO.

You will have the right to submit additional information in writing to the IRO within 10 business days after the date you receive notice from the IRO and, if the IRO receives any additional information within 10 business days after you receive such notice, then (1) the IRO must consider the additional information in its external review, and (2) the IRO is required to forward the additional information submitted by you to the Plan within one business day after the date the IRO receives the information.

Within five business days after the date the IRO receives the external review assignment, the Plan is required to provide the IRO with all documents and information considered by the Plan in making its decision to deny the claim and internal appeal.

Upon receiving from the IRO any additional information submitted by you, the Plan may reconsider its previous decision. If the Plan reverses its decision upon such review, it will notify you and the IRO within one business day after making its reversal, and the IRO must terminate its external review.

The IRO is not bound by the prior decision of the Plan in making its external review decision.

When will I be notified of the decision on my external appeal?

The external reviewer must notify you and the Plan of its decision on your external appeal within 45 days after its receipt of your request for external review.

What information will be included in the IRO's decision on my external appeal?

The notice to you of the IRO's external appeal decision will include the following information:

- A general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial;
- The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision;
- References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence- based standards;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;
- A statement that the IRO's decision is binding, unless other remedies are available to you or the Plan under state or federal law;
- A statement that judicial review may be available to you; and

> A phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Is the external reviewer's decision binding?

The external reviewer's decision is binding upon the parties but does not terminate or preempt your right or the Plan's right to pursue other state or federal law remedies. However, such remedies may or may not exist. Therefore, unless another legal right exists for your claim, the external reviewer's decision will be binding.

Part IV
Investment Fund Information

Investment risk

Accounts invested in stock or bond funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

You should periodically review your selected investment fund choice(s). Should your investment objectives change, you should reevaluate your fund selection(s) and submit any changes to our Customer Care Center. Remember, there have been numerous loss periods in the past in these types of funds and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, you may determine that stock or bond investments are more suitable as longer-term investments rather than for short-term purposes.

Using multiple funds

You may have your HRA account allocated to a single fund, or any combination of two or more available funds.

Transfers

You may transfer among the funds once each calendar month. Transfers are effective within two to three business days of receipt of your request.

Reimbursements (claims)

If you have multiple funds, reimbursements made from your account will be pro-rated, based on your fund allocation percentage on file with the Plan.

Investment funds

You may view information regarding the available investment funds, including performance and a link to each fund company's fund fact sheet and prospectus at **healthinvesthra.com**.

Additional information

You may view additional information regarding the funds (including performance, risk, holdings, management, fund prospectuses, etc.) on the Internet at:

BlackRock
www.blackrock.com

Vanguard Funds
www.vanguard.com

Western Asset Core
www.leggmason.com

US Core Equity
www.us.dimensional.com

Lazard US Equity
www.lazardnet.com

American Funds
www.americanfunds.com

Investment advice

You are encouraged to seek advice regarding these investment funds from your personal financial advisor. The Plan service providers and Customer Care Center do not give investment advice.

Fund operating expenses

Fund operating expenses are deducted from fund assets and include management fees, distribution (12b-1) fees, and other expenses.

Part V
Premium Tax Credit and Your HRA

You may qualify for the Premium Tax Credit (subsidy) if you or a family member purchase health insurance through a state or federal marketplace exchange (sometimes referred to as "Obamacare"). The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through an exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your out-of-pocket premium amount, or you can wait until you file your tax return.

If you purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit, you should know:

1. Marketplace exchange premiums that are not subsidized by the Premium Tax Credit are reimbursable from a full-coverage HRA.
2. Marketplace exchange premiums that are subsidized by the Premium Tax Credit cannot be reimbursed from your HRA.
3. You may not qualify for the Premium Tax Credit for any month during which you have a full-coverage HRA. If you have a full-coverage HRA, are claims-eligible, and have a positive HRA balance or are receiving ongoing HRA contributions, then it may make sense for you to either use up or limit your HRA, as described in more detail below. If you decide to take one of these actions, you should do so before taking the Premium Tax Credit in advance.

IMPORTANT: Keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you cannot qualify for the Premium Tax Credit and you do not need to use up or limit your HRA:

1. You are eligible for coverage in an employer-sponsored group health plan that meets the affordability and minimum value requirements under federal healthcare reform law. (If you are not sure whether this applies to you, check with your employer.);
2. You are eligible for coverage under a governmental plan such as Medicaid, Medicare, CHIP, or TRICARE;
3. Your total family income (including income from investments, retirement benefits, and Social Security) exceeds the maximum amount for eligibility for the Premium Tax Credit (400% of the federal poverty level);
4. You are married but do not file a joint tax return; or
5. You are claimed as a dependent on someone else's tax return.

What can I do if my full-coverage HRA is the only thing keeping me from becoming eligible for the Premium Tax Credit?

If you are claims-eligible and your full-coverage HRA is the only reason you cannot qualify for the Premium Tax Credit, you may consider one of the below options.

1. **Using up your HRA before taking the Premium Tax Credit**. You do not have to take the Premium Tax Credit right away. You could first use up your HRA to reimburse your non-subsidized premiums (and any other qualified medical care expenses incurred since your claims-eligibility date). Then, you could begin taking the Premium Tax Credit in advance to lower your monthly premium, or wait and claim it on your tax return, but only for premiums you paid after using up your HRA. Keep in mind that, if you receive any additional HRA contributions after using up your balance, you will lose eligibility for the Premium Tax Credit for any months during which you have (or had) a positive balance in your HRA.
2. **Electing limited HRA coverage**. If you elect limited HRA coverage, your HRA will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations). If you elect limited HRA coverage for Premium Tax Credit eligibility, you can switch your HRA back to full coverage for any period that you are not taking the Premium Tax Credit. Limited HRA coverage is designed as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal healthcare reform law. To elect limited HRA coverage, submit a **Limited HRA Coverage Election** form. To access paper forms, log in at **healthinvesthra.com** and click **Resources** on the menu bar, or contact our Customer Care Center at customercare@healthinvesthra.com or 1-844-342-5505.

Consider your options carefully

You should consider your options carefully and seek advice from a tax professional. The best decision may vary depending on your individual circumstances, including the amount in your HRA compared to the Premium Tax Credit amount you could receive.

Keep in mind that if you take the Premium Tax Credit without first using up or limiting your HRA as described above, you will likely not qualify for the Premium Tax Credit and may be required to pay it back when you file your tax return for the year.

Where can I get more information?

This plan summary is intended to provide you with general information about the Premium Tax Credit and the options available to you under the HealthInvest HRA Plan. For more information, go to www.irs.gov and type "Premium Tax Credit" in the search bar.

Part VI
Coordination of Benefits with Medicare and MMSEA Section 111 Reporting

If you are entitled to Medicare and are claims-eligible under your HRA account, federal law governs whether your HRA account or Medicare pays or reimburses your medical expenses first. The following summarizes the priority of claims payment as between your HRA account and Medicare unless you have elected limited HRA coverage. For more information about electing limited HRA coverage, refer to Part I.

To comply with federal law you should file your claims in accordance with these primary and secondary payer rules if you have a claims-eligible HRA account and **have not** elected limited HRA coverage.

> If you or your spouse are entitled to Medicare benefits due to your age, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare.

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

MMSEA Section 111 Reporting

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective for HRA plans for plan years beginning on or after October 1, 2010, requires the Plan to report specific information about your HRA account to CMS (Centers for Medicare and Medicaid Services) unless you have either elected limited HRA coverage or certain other exceptions apply. For more information about electing limited HRA coverage, refer to Part I.

To comply with this federal law, the policies and procedures of the Plan will now require you to provide information necessary to comply with the MMSEA Section 111 reporting requirements in order to file claims under your HRA account. In addition, in submitting claims for reimbursement or coverage under your HRA account and Medicare, you should follow the priority of payment rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should pay first, you should contact our Customer Care Center or you can call the Medicare Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

Part VII
Medicare Part D Notice of Non-creditable coverage

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

Introduction

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

Medicare Part D prescription drug coverage became available in 2006.

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

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

Prescription drug coverage provided by this plan is limited to your available account balance and is considered non-creditable. In other words, coverage

provided by this plan is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. The Plan is required to give you this notice to ensure you carefully consider your options, including potentially enrolling in a Medicare prescription drug plan.

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

Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

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

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

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

Information resources

More detailed information about Medicare plans that offer prescription drug coverage is contained in the Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by:

1. Visiting www.medicare.gov for personalized help;
2. Calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for telephone numbers); or
3. Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Note: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at any time from our Customer Care Center.

Part VIII
Privacy Notice

Introduction

This Privacy Notice (the "Notice") describes the legal obligations of HealthInvest HRA (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996

(HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, PHI is health information, including demographic information, collected from you or created or received by the Plan from which it is possible to individually identify you and relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Questions about this Notice or our privacy practices should be directed to our Customer Care Center at 1-844-342-5505 or customercare@healthinvesthra.com.

Who will follow this Notice

The Plan and any service providers that assist in the administration of Plan claims are required by law and by contract with the Plan to follow this Notice. A record of your health care claims reimbursed under the Plan is kept for administration purposes only. This Notice applies to all medical records we maintain.

Effective date

This Notice is effective September 30, 2017.

Privacy pledge – our responsibility

We are required by law to (1) make sure PHI identifying you is kept private; (2) give you certain rights with respect to your protected health information; (3) provide this Notice of our legal duties and privacy/security practices concerning protected health information about you; and (4) follow the terms of the Notice currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make a material change to the Notice, we will provide you with a copy of our revised Privacy Notice by posting the updated Notice on the Plan website, and include information about the revised Notice and how you can obtain it in your next eligible participant account statement delivery.

How we may use and disclose PHI about you

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

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

use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

- **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.
- **As required by law**. We will disclose PHI about you when required to do so by federal, state, or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action.
- **To avert a serious threat to health or safety**. We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician.
- **To Employers or Plan Sponsors**. For the purpose of administering the Plan, we may disclose PHI to certain employees of your employer or plan sponsor. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization.

- **Military and veterans**. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' compensation**. We may release PHI about you for workers' compensation or similar programs providing benefits for work- related injuries or illness.
- **Public health risks**. We may disclose PHI about you for public health activities such as to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).
- **Health oversight activities**. We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- **Lawsuits and disputes**. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved

in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.

- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **National security and intelligence activities**. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required disclosures

The following is a description of disclosures of your PHI we are required to make.

- **Government audits**. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to you**. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other disclosures

- **Personal representatives**. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Spouses and other family members**. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your rights

regarding PHI about you"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

- **Authorizations**. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights regarding PHI about you

You have the following rights regarding PHI we maintain about you.

- **Right to inspect and copy**. You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to our Customer Care Center. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.
- **Right to amend**. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to our Customer Care Center including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
- **Right to an accounting of disclosures**. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

  To request this list or accounting of disclosures, you must submit your request in writing to our Customer Care Center. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the

date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to request restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, healthcare operations, or to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full. To request restrictions, you must submit a written request to our Customer Care Center detailing (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e., your spouse).
- **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to our Customer Care Center specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.
- **Right to be notified of breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI.
- **Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, log in to your account at **healthinvesthra.com** or contact our Customer Care Center at 1-844-342-5505.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the HealthInvest HRA Service Manager, at 1-800-888-8322, who will refer you to your Plan's Privacy Official. You will not be penalized or otherwise retaliated against for filing a complaint.

Other uses of PHI

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

Part IX
Other required notices

Additionally, HealthInvest HRA complies with the requirements of the regulations listed below and does not discriminate with regard to a participant's health-status, genetic information, age, disability, gender, race, or religious beliefs. Eligible expenses for the HealthInvest HRA Plan are defined in Internal Revenue Code § 213(d), but benefits may be limited by your HRA coverage or account balance.

- Genetic Information Nondiscrimination Act (GINA)
- Age Discrimination in Employment Act (ADEA)
- Americans with Disabilities Act (ADA)
- Title VII of the Civil Rights Act and the Pregnancy Discrimination Act (PDA)
- HIPAA portability, privacy, and security requirements
- Mental Health Parity Act (MHPA)
- Mental Health Parity and Addiction Equity Act (MHPAEA)

COBRA NOTICE

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

Introduction

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

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

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to our Customer Care Center.

General information

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

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

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

Qualifying events

> **Participating employee.** If you are a participating employee, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events:

1. you are voluntarily or involuntarily terminated (other than for gross misconduct); or
2. you experience a reduction in hours affecting eligibility.

- **Spouse**. If you are the spouse of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events:
    1. employee is voluntarily or involuntarily terminated (other than for gross misconduct);
    2. employee experiences a reduction of hours affecting eligibility;
    3. you become divorced or legally separated from employee; or
    4. employee passes away.
- **Dependents**. Qualified dependents of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events:
    1. employee is voluntarily or involuntarily terminated (other than for gross misconduct);
    2. employee experiences a reduction of hours affecting eligibility;
    3. employee and spouse become divorced or legally separated;
    4. child reaches age limitation or no longer meets the definition of qualifying child; or
    5. employee passes away.

Qualifying event notification

The Plan will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits.

When the qualifying event is due to an active participating employee's

- voluntary or involuntary termination (other than for gross misconduct);
- reduction of hours of employment affecting eligibility; or
- death, the employer must notify the Plan within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the Plan within 60 days of the occurrence of such event, using the **COBRA Event Notice** form. The Notice must be mailed or hand delivered to the Plan, and is available upon request upon calling 1-844-342-5505. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation and additional documentation may be required. If the Notice is late, incomplete, or is not submitted as outlined in the Notice of Procedures provided on the aforementioned form, no qualified beneficiary may be offered the opportunity to elect COBRA coverage.

COBRA continuation period

The COBRA continuation period is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA.

COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's

- voluntary or involuntary termination (other than for gross misconduct); or
- reduction of hours of employment affecting eligibility.

A maximum of up to 36 months is allowed when the qualifying event is due to a participating employee's

- legal separation or divorce;

- death; or
- when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension

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

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

Information resources

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

USERRA RIGHTS

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

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

Should you have any questions regarding USERRA rights, please contact our Customer Care Center.

FMLA NOTICE

The HealthInvest HRA Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your HealthInvest HRA account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave. For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

WOMENS' HEALTH AND CANCER RIGHTS ACT NOTICE

The Plan will provide coverage for all stages of reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to provide a symmetrical appearance; prostheses; and coverage of physical complications at all stages of the mastectomy, including lymphedemas. Availability of benefits may be limited by your HRA coverage and account balance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

TRICARE

Under statutory amendments enacted in 2006, and final regulations issued in 2010, employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under the military's health care program, known as TRICARE. In particular, employers are prohibited from providing financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan

Due to these federal regulations, if you are a TRICARE-eligible employee, your employer is required to enroll you under or direct your contributions to the HealthInvest HRA Limited HRA Plan (while you are employed) and the Post-separation Plan (for separated employees only). These plan coverages are not primary to your employer's group health plan.

MEDICAL SUPPORT ORDERS

Participants and covered individuals may obtain a copy of the qualified medical support order procedure from the Plan, free of charge. To request a copy, please contact our Customer Care Center at 1-844-342-5505 or customercare@healthinvesthra.com.

Part X
Exemption from annual limit restrictions

The Affordable Care Act prohibits health plans from applying dollar limits on coverage for certain benefits.

Your HRA has been designed based upon exemptions from these annual limits restrictions and in accordance with guidance issued by the Internal Revenue Service and the U.S. Department of Health and Human Services.

Accordingly, your HRA reimbursements (claims) are limited to your available account balance. This means coverage provided to you by this Plan may not reimburse all of the out-of- pocket medical care expenses you may incur.

Part XI
Terms & Conditions

By enrolling and participating in the HealthInvest HRA Plan and taking any action with respect to your HRA benefits under the Plan, you agree to the following Terms & Conditions. You agree that the Plan and the parties involved in this Plan (including, but not limited to, the employer, plan sponsor, plan administrator, bargaining representative, the Master Trustee, the HealthInvest HRA Service Manager Plan service providers, and the agents of each, collectively referred to as the "Plan and its agents") cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any tax, charge, penalty, assessment, or other amount that is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan and its agents harmless with respect to such withholding or any failure to withhold or pay such amounts and any other actions taken in good faith for the operation of the Plan. You understand that for proper administration of the Plan and compliance with applicable law, you must provide true and accurate information to the Plan and regularly confirm and update your enrollment information, including name, address, phone number, dependents, and social security numbers for yourself and your dependents. Information submitted to the Plan fraudulently may result in adverse tax consequences or penalties and/or your termination from the Plan. You also understand that it is your responsibility to review each statement to confirm that there are no investment or financial errors reflected on your account. Any errors must be reported by you to the Plan within ninety (90) days after the error is first viewed by you online or first reflected in a statement or other written information delivered to you by the Plan and its agents.

E-communication Terms & Conditions. For your e-communication election to be effective, you must provide the Plan with your e-mail address. The electronic documents you will receive include e-statement notifications and newsletters, claims processing notifications, and other important Plan information. Please note the following:

- You may withdraw your consent for electronic documents at any time at no charge
- To update your e-communication election or email address, please login to **healthinvesthra.com** and click on **My Profile** on the menu bar
- It is your responsibility to keep your email address current with the Plan. If your electronic documents are returned to the Plan due to an undeliverable e-mail address, the Plan may remove your e-communication election.
- Any electronically delivered documents will **not** be mailed to you by US Mail
- You can view and print copies of your electronic documents or request paper copies (at no charge) from our Customer Care Center
- You will need Adobe Acrobat Reader software loaded on a computer in order to access electronic documents. A free copy of Adobe Acrobat Reader is available at www.adobe.com

Appendix A
Definition of Dependent

Your spouse and dependents are eligible for coverage under your health reimbursement arrangement (HRA). Dependents must meet the definition of Qualifying Child or Qualifying Relative. These requirements are defined by Internal Revenue Code Sections 105(b) and 152.

A **Qualifying Child** is someone who:

1. Is the participant's son or daughter, stepchild, foster child; and
2. Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico; and
3. Is either:
   a. Age 26 or younger at the end of the calendar year in which expenses were incurred; or
   b. Permanently and totally disabled.

OR

1. Is a brother, sister, stepbrother, stepsister, or a descendant of the participant's son, daughter, stepchild or foster child; and
2. Is either:
   a. Under age 19; or
   b. Under age 24 and a full-time student; or
   c. Permanently and totally disabled; and
3. Is younger than the participant; and
4. Lives with participant for more than half the year; and
5. Does not provide more than half of his or her own support; and
6. Will not file a joint tax return for the year in which the expense was incurred; and
7. Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico

Qualifying Child of Divorced or Separated Parents. A participant's child is treated as the dependent of both parents for the purposes of health plan coverage if during the calendar year in which expenses were incurred: (1) the participant's child is in the custody of the participant or their other parent for more than half the year; (2) the participant's child receives over half of his or her support during the year from the participant or their other parent.

A **Qualifying Relative** is someone who:

1. Is the participant's:
   a. Son, daughter, stepchild, foster child, or a descendant of any of them (for example, a grandchild); or
   b. Brother, sister, or a son or daughter of either of them; or
   c. Father, mother, or an ancestor or sibling of either of them (for example, the participant's grandmother, grandfather, aunt, or uncle); or
   d. Stepbrother, stepsister, stepfather, stepmother, son- in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or
   e. Any other person (other than the participant's spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and
2. Will not be a qualifying child (see Qualifying Child above) of any other person as of the last day of the calendar year in which expenses were incurred; and
3. For whom the participant provided over half the support for the calendar year; and
4. Is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico

Domestic Partners. Unless your domestic partner qualifies as a legal spouse under state law, a domestic partner must meet all of the **Qualifying Relative** requirements to be eligible for coverage under your HRA. If you need to list your domestic partner as a dependent, please give us a call.

Appendix B
ERISA Supplement

If your welcome packet states that your Plan is subject to ERISA, this supplement contains additional information regarding your Plan and your rights under the Plan as required by ERISA. You may also receive a Summary of Material Modifications (SMM) from time to time, which is required by ERISA to provide you with timely notice of certain material changes to the Plan or information required to be included in the SPD. You should read the HealthInvest HRA SPD (as updated from time to time), any SMMs, your welcome packet, and this supplement together to fully understand your benefits and your rights under the HealthInvest HRA Plan. You may obtain a copy of the most current SPD and any SMMs by logging into your account at **healthinvesthra.com** and clicking Resources. If you misplace your welcome packet, you may request a replacement copy from our Customer Care Center.

Your Rights

As a participant in the HealthInvest HRA Plan you may be entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all Plan participants shall be entitled to the rights described below.

Receive Information about Your Plan and Benefits

You can examine, without charge, at the Plan's office and at other specified locations all documents governing the Plan, i collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration.

You can obtain, upon written request to the Plan, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan may make a reasonable charge for the copies.

The Plan is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

Continue Group Health Plan Coverage

You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and covered individuals. No one, including your plan sponsor, employer, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge,

and to appeal any denial, all within certain time schedules. Be sure to review the Procedure for Dispute Claims under Part III in this Summary Plan Description for more details regarding your enforcement rights under the Plan.

After exhausting the Plan's claims procedures, under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact our Customer Care Center at 1-844-342-5505 or customercare@**healthinvesthra.com**. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HealthInvest HRA Customer Care Center

1-844-342-5505
customercare@healthinvesthra.com
www.healthinvesthra.com

Download our mobile app, HRAgo, today!

Google Play App Store

Plan Adoption Information

To learn more about adopting HealthInvest HRA for your group, visit **www.ajg.com/healthinvesthra** or contact:

Dutch Ross
National Sales Director
HealthInvest HRA
1-800-888-8322 | dutch_ross@ajg.com

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