VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
STANDARD HEALTH CARE REIMBURSEMENT PLAN
FOR PUBLIC EMPLOYEES IN THE NORTHWEST

(FULL 213(d) MEDICAL BENEFITS COVERAGE)

AMENDED AND RESTATED
As of January 1, 2014

Article I.
General Provisions

1.1 Name. The name of this Plan is the VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION STANDARD HEALTH CARE REIMBURSEMENT PLAN FOR PUBLIC EMPLOYEES IN THE NORTHWEST ("HRA VEBA Standard HRA Plan" or "Plan"). This Plan is offered by a voluntary employees' beneficiary association under Internal Revenue Code § 501(c)(9). The effective date for the Plan is October 1, 1990.

1.2 Plan Documents. This Plan document, together with the Trust Agreement, the individual Participant Enrollment Form, and the Employer Adoption Agreement shall constitute this entire Plan. This Plan document is hereby amended and restated and replaces the prior Plan document in its entirety.

1.3 Integrated HRA Plan.

1.3.1 Integration. This Plan is designed to be integrated with primary group health plan coverage (each a "Qualified Group Health Plan") that meets the requirements of Section 2711 of the Public Health Service Act, as added by PPACA, and that provides minimum value as defined by IRC §36B(c)(2)(C)(ii). The Trustees shall establish such rules, policies, and procedures as they deem necessary or desirable to achieve the Plan's compliance with or exemption from Section 2711 and other applicable regulations promulgated or regulatory guidance issued under PPACA, including or in addition to the following:

1.3.1.1 Participant Accounts shall be considered integrated under the terms of this Plan and eligible to receive contributions only if, at the time such contribution is Credited, the Participant for which such Participant Account is established is (a) eligible to enroll in his or her Employer's Qualified Group Health Plan and (b) has certified or attested to the Employer that he or she is actually enrolled in the Employer's or another Qualified Group Health Plan.

1.3.1.2 Except as specifically permitted by Section 1.3.2, Participant Accounts of Participants who do not meet the requirements of Section 1.3.1.1 will not be considered integrated or eligible to receive contributions under this Plan.

1.3.2 Grandfathered and other Permitted Contributions. Contributions into Participant Accounts are permitted only if:

1.3.2.1 ***Grandfathered (Pre-2013)***. Such contributions were Credited prior to January 1, 2013, or

1.3.2.2 ***Grandfathered (Post 2012; Pre-2014).*** Such contributions were Credited after January 1, 2013 but before January 1, 2014, pursuant to contribution terms or methods that were approved, documented, or otherwise in effect before January 1, 2013, or as otherwise provided or permitted by applicable law; or

1.3.2.3 ***Integrated.*** Such contributions were contributed into Participant Accounts that qualify as integrated pursuant to Section 1.3.1.

1.3.2.4 ***Forfeiture Reallocations or Re-contributions.*** Such contributions were the result of forfeitures re-allocated or re-contributed as permitted by Section 5.4.

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

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

1.4.2 Application of Forfeitures. Any positive account balance that is waived and forfeited pursuant to this Section 1.4 shall be applied as provided in Section 5.4.

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

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

1.7 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Benefits as described in Section 5.1.

"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 Employer actions or adoption procedures.

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

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

"Employee" means any current or former employee of the Employer, as defined by Treasury Regulation § 1.501(c)(9)-2(b), except employees excluded as a result of collective bargaining agreements, agreements substantially similar to collective bargaining agreements, or as a result of an individual Employer's nondiscriminatory employer benefits policies.

"Employer" means a county, city, or town, or special purpose district, or similar entity in Washington, Oregon, and Idaho, whose purpose is to provide public services to its citizens, and is authorized to do so by state statute.

"Employer Account" refers to the account maintained with respect to any Employer to record its contributions which have not been allocated to Participant Accounts, and adjustments related thereto, and established for the purpose of providing benefits permitted under IRC § 501(c)(9).

"Employer Adoption Agreement" means an Employer Adoption Agreement executed by an Employer and accepted by the Trust, as the same may be amended and restated or replaced from time to time.

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

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

"Participant" means, subject to Article II, a current or former Employee for whom at least one Employer contribution has been received by the Trust and for whom a completed and signed Participant Enrollment Form has been received by the Third-party Administrator.

"Participant Account" refers to the account maintained for a Participant to record his/her share of the contributions of the Employer and adjustments relating thereto.

"Participant Effective Date" for any Participant means, as applicable, either (i) the date specified by the Employer on a completed and signed Participant Enrollment Form for such Participant or (ii) if no date is specified for a Participant on the completed and signed Participant Enrollment Form, the date on which both a contribution and the Participant Enrollment Form for such Participant have been received by the Third-party Administrator or (iii) if an Employer contribution has been received in the form of transferred assets from a former plan, the date specified by the Employer in the applicable transfer agreement on which the employee shall become a Participant; provided that, the Participant Effective Date cannot be a date prior to the Employee's original hire date with the Employer or the Effective Date of this Plan (or in the case of a transfer under (iii) the effective date of the former plan).

"Participant Enrollment Form" means the form provided by the Trustees that must be completed by the Employee in order to participate in this Plan.

"Plan Year" is from October 1 to September 30, except the first year for this Plan with an effective date other than October 1 shall run from such effective date until the next September 30.

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

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

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

"Third-party Administrator" means a third-party appointed or contracted by the Trustees from time to time to provide record-keeping, claims-payment, and other plan administration services to all or a portion of the Trust or this Plan.

"Trust" or "Trust Agreement" refers to the Voluntary Employees' Beneficiary Association for Public Employees in the Northwest Trust, as the same may be amended, restated, or replaced from time to time.

"Trustees" refers to the individuals serving as Trustees in accordance with the Trust.

Article II.
Participation

2.1 In General. Subject to the limitations of this Article II, and subject to the eligibility provisions of applicable local and State law, an Employee becomes a Participant under this Plan on the Participant Effective Date.

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

2.3 Duration of Participation. Upon becoming a Participant in the Plan, an Employee's status as a Participant shall continue for as long as the Participant has a positive balance in any Participant Account. In addition, Participant status shall continue for forty-five (45) days during which all Participant Accounts for such Participant remain exhausted. If all Participant Accounts for such Participant remain exhausted for forty-five (45) days, and the Third-party Administrator has not received notice from the Employer that additional funds will be added to any of such Participant Accounts, then the Employee's status as a Participant and eligibility to file claims for reimbursement of Qualified Health Care Benefits shall temporarily terminate the first day immediately after such 45-day period. If a contribution or transfer is subsequently received into any Participant Account for such Participant before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be restored back to the original effective date of such Participant Account, and such Participant shall be eligible to file claims for expenses incurred during the period his or her Participant status was temporarily terminated. If a contribution or transfer is not received into such Participant Account before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be permanently terminated as of the end of such second Plan Year. An eligible Employee who has permanently lost his or her status as a Participant at the end of the second consecutive Plan Year may subsequently become a Participant in the Plan as prescribed in Section 2.1.

Article III.
Funding of Benefits

3.1 Contributions. Each individual Employer shall contribute or transfer assets to this Plan on behalf of its eligible Employees on terms pursuant to collective bargaining agreements, other written agreements, or Employer benefits policies, whichever is applicable. Employer contributions or transfers shall be specifically allocated to one or more Participant Accounts or to an Employer Account for the purpose of providing for payment of the Benefits described hereinafter or maintained in an Employer Account, as directed by the Employer. The liabilities, expenses, costs and charges associated with each particular Participant and Employer Account shall be charged against the assets of the Trust held with respect to that particular Participant or Employer Account.

Article IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Third-party Administrator to reflect that portion of the Trust with respect to each Participant and with respect to each Employer (regarding its contributions which have not been allocated to Participant Accounts), and the contributions, income, losses, increases and decreases for expenses or benefit payments, transfers and adjustments attributable to each such account. The Trustees shall not be required to maintain separate investments for any account.

4.2 Receipt of Contributions or Transfers. Contributions or transfers for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Trustees consistent with Participant investment elections. If any portion of any Plan contribution is not allocable to a specific Participant Account or an Employer Account

pursuant to instructions from the Employer, or if a Participant Enrollment Form is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to a non-interest-bearing account for unallocated funds until such time as further instructions are received from the Employer, or the Administrator may return such contribution to the Employer. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior qualified plan on behalf of an Employee for whom an Enrollment Form is not submitted will not be returned to the Employer and will be treated as directed by the Employer in writing and in accordance with the policies and procedures established by the Trustees or Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 FIRST, allocate and credit any Employer contribution or transfer to this Plan that is made during the month to a Participant Account or Employer Account. Investment earnings or losses will accrue from the date the contribution or transfer is credited to a Participant Account or Employer Account, and funds will be invested as directed by the Participant or Employer in accordance with the policies and procedures of the Administrator, and investment earnings or losses will accrue from the date the contribution or transfer is credited to the Participant Account or Employer Account in accordance with the policies and procedures of the Administrator;

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

4.3.3 THIRD, charge to each Participant Account and Employer Account all fees, payments, transfers, adjustments, or distributions made under this Plan to or for the benefit of the Participant or his Dependents, or the Employer, as the case may be, that have not been charged previously.

4.4 Use of Employer Accounts. Funds within each Employer Account are, at the direction of the Employer, either to be allocated to Participant Accounts or to be applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

Article V.
Qualified Health Care Benefits

5.1 Qualified Health Care Benefits. Qualified Health Care Benefits must be a reimbursement for medical care expenses as defined by IRC § 213(d) and excludable from income under IRC §§ 105 and 106, as amended from time to time. Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan, and reimbursements may not be made for items paid or payable by any other insurance contract or plan, 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. Reimbursement may be made for premiums due for any part of Medicare.

A "Limited HRA VEBA Plan Coverage" option may be available to Participants who desire to limit their Qualified Health Care Benefits to coordinate with the Participant's other benefit plans. Such Limited HRA VEBA Plan Coverage shall be subject to the limitations and provisions of applicable law and in accordance with rules, regulations and limitations established by the Trustees from time to time. Limited HRA VEBA Plan Coverage constitutes minimum essential coverage, as defined under IRC § 5000A, and will not be effective to enable a Participant to become potentially eligible for an IRC § 36B premium tax credit. To become eligible for an IRC § 36B premium tax credit, a Participant must make a forfeiture election under Section 1.4 or elect Pre-Medicare Limited-Scope coverage under Section 1.5.

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

5.1.1 Expenses of Participant or Dependent(s). Qualified Health Care Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s).

5.1.2 Claims for Benefits. Participants may file claims for Qualified Health Care Benefits on or after the date they become a Participant, provided the Third-party Administrator has received a properly completed Participant Enrollment Form, a contribution or transfer on behalf of the Participant and any additional information that, in the discretion of the Third-party Administrator, is required or necessary for the Plan or Third-party Administrator to comply with applicable law, including without limitation, the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.3 Payment of Benefits. Qualified Health Care Benefits shall include (but are not limited to) premiums reimbursed directly to the Participant. Payment or reimbursement of Qualified Health Care Benefits shall be made in accordance with rules, regulations and limitations established by the Trustees from time to time consistent with the requirements of the Internal Revenue Code.

5.2 Termination of Benefits. All Benefits for any Participant will terminate as of the date when such Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

5.3 Dependent Health Care Benefits in the Event of Death. After the death of a Participant and if no Dependents remain eligible for Qualified Health Care Benefits, any vested funds then remaining in the deceased Participant's Participant Account shall be forfeited and applied as provided in Section 5.4.

5.4 Forfeiture of Participant Account Balance. In the event any funds within a Participant Account are forfeited in accordance with the terms of the Plan documents, such forfeited funds shall be applied as follows, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator:

5.4.1 If such forfeiture occurs before January 1, 2014, such forfeited funds shall be reallocated in equal amounts to all Participants of the deceased or forfeiting

Participant's Employer within the Trust that have a positive balance at the time of such reallocation.

5.4.2 If such forfeiture occurs on or after January 1, 2014, such forfeited funds shall be transferred to a temporary forfeiture account held within the Trust on behalf of all Participants of the deceased or forfeiting Participant's Employer within the Trust, to be re-contributed as future contributions to Participants eligible for contributions or otherwise applied, as directed by the Employer.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to one or more surviving Dependents for Benefits under the Plan in the event of the Participant's death, shall be limited (in the aggregate) to the balance in such Participant's Participant Account. None of the Employer, Trustees or Third-party Administrator, or any of their agents, subcontractors, representatives, officers, or employees shall be responsible for any Benefits under the Plan.

6.2 Investment of Participant Accounts and Employer Accounts. The Trustees shall determine the options to be made available through the Trust for the investment of Participant Accounts and Employer Accounts. For each Participant Account, the Participant shall elect one or more of the investment options into which the funds in such Participant Account will be allocated. For each Employer Account, the Employer (or a qualified investment manager appointed by the Employer) shall elect one or more of the investment options into which the funds in such Employer account will be allocated. Participant and Employer Account elections shall be made and changed in accordance with procedures established by the Trustees and as may be amended from time to time. In the event no election has been made with respect to a Participant Account or Employer Account, such Account shall be invested in one or more options whose investment objective is stable value. Separate investments shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts.

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

6.3.1 To reimburse Benefits for premium amounts paid to an insurance company, health benefit plan, HMO or PPO for qualified insurance premiums, including COBRA or qualified long-term care premiums; or

6.3.2 To reimburse Benefits for Qualified Health Care Benefits; or

6.3.3 To reimburse out-of-pocket premium expenses for Medicare coverage.

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

6.4.1 If the Claimant's request for benefits is approved by the Third-party Administrator, it shall notify the Claimant of such approval and distribute such benefits to the Claimant.

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

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

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

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

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

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

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for Benefits is not received by the Claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, the request shall be deemed denied as of that date.

6.4.5 Any Claimant whose request for Benefits has been denied or deemed denied, in whole or in part, or such Claimant's authorized representative, may appeal said denial of Plan benefits by submitting to the Third-party Administrator a written request

for a review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than one hundred eighty (180) days from the date the Claimant received written notification of the Third-party Administrator's initial denial of the Claimant's request for Benefits or from the date the claim was deemed denied, unless the Third-party Administrator, upon the written application of the Claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

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

6.4.7 Upon receiving a request by a Claimant, or his authorized representative, for a review of a denied claim, the Third-party Administrator shall deliver the complete file to the Trustees, who shall consider such request promptly and shall advise the Claimant of their decision within thirty (30) days from the date on which said request for review was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said denied claim. In the event special circumstances require an extension of time for reviewing said denied claim, the Third-party Administrator shall, prior to the expiration of the initial 30-day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Trustees expect to render their decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the Claimant's request for review was received by the Third-party Administrator. The Trustees' decision shall be furnished to the Claimant and shall:

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

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

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

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

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

6.4.8 The Trustees may, in their discretion, determine that a hearing is required in order to properly consider the Claimant's request for review of a denied claim. In the event the Trustees determine that such hearing is required, such determination shall, in

and of itself, constitute special circumstances permitting an extension of time in which to consider the Claimant's request for review.

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

Once the review above is complete, the Third-party Administrator has one (1) business day to notify the Claimant in writing of the outcome of its review. If Claimant is not eligible for external review, the notice must include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If the Claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four-month filing period to complete the filing.

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

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

6.5 Mechanics of Payment from Employer Accounts. The Employer, or its agent or authorized officer, may submit a request to the Third-party Administrator to transfer funds from the Employer's Account to be allocated to Participant Accounts or applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

6.6 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).

6.6.1 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:

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

6.6.1.2 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;

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

6.6.1.4 report to the Privacy Official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.6.1.5 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;

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

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

6.7 Employer Uses of Protected Health Information.

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

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

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

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

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

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

"Privacy Official" means the Vice Chairman of the Board of Trustees or such other person appointed from time to time by the Board of Trustees to serve in such capacity.

An Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA.

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

Enrollment and disenrollment information shall include, without limitation, name, 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 acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

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

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

6.7.4 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 6.7.5 and obtaining

written certification pursuant to Section 6.7.8, the Plan may disclose PHI and Electronic PHI to an Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

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

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

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

6.7.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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) disclosed to it by the Plan, such Employer shall:

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

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

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

6.7.5.4 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;

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

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

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

6.7.5.8 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;

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

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

6.7.6 Additional Requirements. Each Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

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

modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

6.7.7 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 that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

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

6.7.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to an Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 6.7.5 and all other conditions and requirements of this HIPAA Plan Amendment.

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Article VII.
Administrator

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

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

7.1.2 To determine entitlement to Benefits under the provisions of Article VI.

7.1.3 To compute and certify to the Trustees the amount and kind of benefits payable to the Participants and their Dependents.

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

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

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

7.1.7 To facilitate the investment elections made by Participants and Employer in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

7.1.9 To inform the Trustees with respect to the investment of Participant and Employer Accounts.

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

7.2 Information. To enable the Third-party Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions on behalf of a Participant and Participant entitlement to benefits. The Employer shall also supply the Third-party Administrator with full and timely information on all matters relating to Employer contributions to an Employer Account. The Third-party Administrator shall maintain such information and advise the Trustees of such other information as may be pertinent to the Trustees' administration of the Trust.

The Third-party Administrator shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action for the purpose of performing its duties under the Plan or the Trust, and the Third-party Administrator shall have the right to rely on information provided by the Employer pursuant to

this section with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action.

7.2.1 The Trust shall provide to each Participant, information necessary to use their Participant Account and receive reimbursement of Benefits. The information will include a summary of the Plan, including claim procedures and instructions on how to acquire plan forms. The Trust shall also communicate within a reasonable amount of time after receipt of the contribution or transfer an acknowledgement to the Participant with a Participant Account or the Employer with an Employer Account, whichever is applicable, acknowledging establishment of the Participant Account or Employer Account; confirmation of the amount received; a summary of the Plan and information on filing claims with copies of the necessary forms, if applicable; and a toll-free contact telephone number for error corrections or questions.

7.2.2 The Trust shall provide a written statement prepared upon a Participant's or Employer's request, and at least semi-annually for each Participant and Employer, which shall include the following information: Participant's or Employer's name and address, whichever is applicable; Participant Account number; contributions; total Account value at statement date; interest earned or other shared gain or loss; payout and disbursement activities, ending/forward balance; toll-free contact telephone number for error corrections or questions on reading the statement.

7.2.3 The Trust shall provide a monthly unaudited report to the Trustees including the following: income statement, balance sheet, year to date budget, number of Participant Accounts, and other such reports which are permitted by law, the Trustees and/or Employer requests and agreed to by the Plan Third-party Administrator.

7.3 Compensation, Expenses, and Governmental Fees, Taxes and Assessments. Consultant and investment manager expenses for the Plan may be paid by reasonable reductions of investment earnings and/or assessments from the Participants' Accounts as determined by the Trustees from time to time. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, plan administration software or technology, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, the Trustees, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Trustees from time to time.

7.4 Consultants, Advisors & Managers. The Trustees may employ such consultants, advisors, investment managers, Third-party Administrators, and other service providers as they reasonably deem necessary or useful in carrying out their duties hereunder, all of which shall be considered expenses of administering the Plan.

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

7.6 Notices & Directions. The address for delivery of all communications shall be:

HRA VEBA Trust
c/o VEBA Service Group, a Division of Gallagher Benefit Services, Inc.
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4537
(509) 838-5571 Telephone
(509) 838-5613 Fax
mark_wilkerson@ajg.com

7.7 Funding Policy & Procedures. The Trustees shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employers and Trustees that this Plan, and the payment of Benefits hereunder, will be continued indefinitely, but continuance of this Plan or contributions to this Plan is not assumed as a contractual obligation of the Employers or the Trustees. This Plan may be amended or terminated only as provided in this Article.

8.2 Exclusive Benefit Rule. It shall be impossible for any part of the funds in Participant Accounts under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

8.3 Amendments.

8.3.1 The Trustees shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments.

8.3.2 Such amendments shall be as set forth in an instrument in writing executed by the Trustees. Any amendment may be current, retroactive, or prospective, in each case as provided therein and provided, however, that such amendment must comply with Article III of the Trust Agreement.

8.4 Discontinuance of Contributions. Each Employer shall have the right to discontinue contributions without prior notice by delivering written notice of termination to the Trustees.

8.5 Termination of Plan. The Trustees shall have the right to terminate this Plan without prior notice unless required by law by delivering written notice of termination to the Employers and Participants. In case of termination, the Trustees shall also notify the Employers and Participants of the Trustees' decision with regard to disposition of the assets, based on the following options, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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

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

8.5.3 An immediate cash payment to another IRC § 501(c)(9) trust or another program providing benefits permitted by IRC § 501(c)(9); or

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

In any event, the Employers and the Trustees shall work to prevent adverse consequences to Participants and other Employers contributing to the Trust as a result of any Employer's decision or action with respect to these options. An Employer whose Employer Account or whose Employees' Participant Accounts are to be transferred from the Trust agrees to pay the Trust all reasonable costs resulting from the disposition or transfer of the assets that are to be transferred.

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, the Employer Adoption Agreement, and the Participant Enrollment Form are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of this Plan and the Participant Enrollment Form, the Employer Adoption Agreement and the terms of the Trust, such conflict shall be resolved first by reference to the Trust, except as more specifically addressed in the Plan, then the Plan, then the Employer Adoption Agreement, then the Participant Enrollment Form.

9.2 Applicable Law; Severability. Except as required in § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), this Plan shall be construed, administered, and governed under the laws of the State of Washington. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

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

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

9.5 Forfeiture of Unclaimed Participant Accounts. The account balance in a Participant Account shall be forfeited and applied as provided in Section 5.4 if (a) within the Unclaimed Account Forfeiture Period (defined below) at least two communications from the Plan to the Participant have been returned as undeliverable and (b) during the entire Unclaimed Account Forfeiture Period, the following conditions exist:

9.5.1 Such Participant Account has a positive account balance and is claims-eligible;

9.5.2 No contributions to or withdrawals from the Participant Account have occurred; and

9.5.3 No communications or other expressions of interest have been received

by the Third-party Administrator from or on behalf of the Participant of such Participant Account.

For purposes of this Section 9.5, the "Unclaimed Account Forfeiture Period" shall be a continuous period that is equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for such Participant Account or (ii) three years.

9.6 Limitation on Rights. Neither the establishment of this Plan, nor any modification or amendment thereof, nor the payment of any Benefits, nor the issuance of any insurance contracts shall be construed as giving any Participant, or any person whomsoever, any legal or equitable right against the Trustees, the State of Washington, its agencies, officers, employees, and institutions of higher education, or the Employers or Administrator or Third-party Administrator or any of their agents or employees, nor any right to the assets of the Plan, except as expressly provided herein.

9.7 Assignment. The interest of any Participant or Employer in any assets held on his or its behalf by the Trustee shall not be subject to assignment or alienation, either by voluntary or involuntary act of the Participant or the Employer or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process, except to the extent required by law.

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

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IN WITNESS WHEREOF, Doug Detling, Chairman of the Board of Trustees, being duly authorized, on this 13th day of December, 2013 signed this Plan Document.

By: _____
Doug Detling, Chairman

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
STANDARD HEALTH CARE REIMBURSEMENT PLAN
FOR PUBLIC EMPLOYEES IN THE NORTHWEST

(PRE-MEDICARE LIMITED-SCOPE COVERAGE)

AMENDED AND RESTATED
As of January 1, 2014

Article I.
General Provisions

1.1 Name. The name of this Plan is the VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION STANDARD HEALTH CARE REIMBURSEMENT PLAN FOR PUBLIC EMPLOYEES IN THE NORTHWEST ("HRA VEBA Standard HRA Plan" or "Plan"). This Plan is offered by a voluntary employees' beneficiary association under Internal Revenue Code § 501(c)(9). The effective date for the Plan is October 1, 1990.

1.2 Plan Documents. This Plan document, together with the Trust Agreement, the individual Participant Enrollment Form, and the Employer Adoption Agreement shall constitute this entire Plan. This Plan document is hereby amended and restated and replaces the prior Plan document in its entirety.

1.3 Pre-Medicare Limited-Scope Coverage. For any Participant who has irrevocably elected Pre-Medicare Limited-Scope Coverage under this VEBA Standard HRA Plan:

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

1.3.2 Full 213(d) Benefits after Medicare-eligibility. After the earlier to occur of (i) the Participant's eligibility for Medicare due to age or permanent disability or (ii) the Participant's death, the Pre-Medicare Limited-Scope Coverage under Section 1.3.1 may be terminated, and Qualified Health Care Benefits for expenses incurred by such Participant and his or her Dependents after the date of such termination of Pre-Medicare Limited-Scope Coverage shall include reimbursement for any expense that constitutes a Qualified Health Care Benefit.

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

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

1.5 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Benefits as described in Section 5.1.

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

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

"Employee" means any current or former employee of the Employer, as defined by Treasury Regulation § 1.501(c)(9)-2(b), except employees excluded as a result of collective bargaining agreements, agreements substantially similar to collective bargaining agreements, or as a result of an individual Employer's nondiscriminatory employer benefits policies.

"Employer" means a county, city, or town, or special purpose district, or similar entity in Washington, Oregon, and Idaho, whose purpose is to provide public services to its citizens, and is authorized to do so by state statute.

"Employer Account" refers to the account maintained with respect to any Employer to record its contributions which have not been allocated to Participant Accounts, and adjustments related thereto, and established for the purpose of providing benefits permitted under IRC § 501(c)(9).

"Employer Adoption Agreement" means an Employer Adoption Agreement executed by an Employer and accepted by the Trust, as the same may be amended and restated or replaced from time to time.

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

"Participant" means, subject to Article II, a current or former Employee for whom at least one Employer contribution has been received by the Trust and for whom a completed and signed Participant Enrollment Form has been received by the Third-party Administrator.

"Participant Account" refers to the account maintained for a Participant to record his/her share of the contributions of the Employer and adjustments relating thereto.

"Participant Effective Date" for any Participant means, as applicable, either (i) the date specified by the Employer on a completed and signed Participant Enrollment Form for such Participant or (ii) if no date is specified for a Participant on the completed and signed Participant Enrollment Form, the date on which both a contribution and the Participant Enrollment Form for such Participant have been received by the Third-party Administrator or (iii) if an Employer contribution has been received in the form of

transferred assets from a former plan, the date specified by the Employer in the applicable transfer agreement on which the employee shall become a Participant; provided that, the Participant Effective Date cannot be a date prior to the Employee's original hire date with the Employer or the Effective Date of this Plan (or in the case of a transfer under (iii) the effective date of the former plan).

"Participant Enrollment Form" means the form provided by the Trustees that must be completed by the Employee in order to participate in this Plan.

"Plan Year" is from October 1 to September 30, except the first year for this Plan with an effective date other than October 1 shall run from such effective date until the next September 30.

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

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

"Third-party Administrator" means a third-party appointed or contracted by the Trustees from time to time to provide record-keeping, claims-payment, and other plan administration services to all or a portion of the Trust or this Plan.

"Trust" or "Trust Agreement" refers to the Voluntary Employees' Beneficiary Association for Public Employees in the Northwest Trust, as the same may be amended, restated, or replaced from time to time.

"Trustees" refers to the individuals serving as Trustees in accordance with the Trust.

Article II.
Participation

2.1 In General. Subject to the limitations of this Article II, and subject to the eligibility provisions of applicable local and State law, an Employee becomes a Participant under this Plan on the Participant Effective Date.

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

2.3 Duration of Participation. Upon becoming a Participant in the Plan, an Employee's status as a Participant shall continue for as long as the Participant has a positive balance in any Participant Account. In addition, Participant status shall continue for forty-five (45) days during which all Participant Accounts for such Participant remain exhausted. If all Participant Accounts for such Participant remain exhausted for forty-five (45) days, and the Third-party Administrator has not received notice from the Employer that additional funds will be added to any of such Participant Accounts, then the Employee's status as a Participant and eligibility to file claims for reimbursement of Qualified Health Care Benefits shall temporarily terminate the first day immediately after such 45-day period. If a contribution or transfer is

subsequently received into any Participant Account for such Participant before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be restored back to the original effective date of such Participant Account, and such Participant shall be eligible to file claims for expenses incurred during the period his or her Participant status was temporarily terminated. If a contribution or transfer is not received into such Participant Account before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be permanently terminated as of the end of such second Plan Year. An eligible Employee who has permanently lost his or her status as a Participant at the end of the second consecutive Plan Year may subsequently become a Participant in the Plan as prescribed in Section 2.1.

Article III.
Funding of Benefits

3.1 Contributions. Each individual Employer shall contribute or transfer assets to this Plan on behalf of its eligible Employees on terms pursuant to collective bargaining agreements, other written agreements, or Employer benefits policies, whichever is applicable. Employer contributions or transfers shall be specifically allocated to one or more Participant Accounts or to an Employer Account for the purpose of providing for payment of the Benefits described hereinafter or maintained in an Employer Account, as directed by the Employer. The liabilities, expenses, costs and charges associated with each particular Participant and Employer Account shall be charged against the assets of the Trust held with respect to that particular Participant or Employer Account.

Article IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Third-party Administrator to reflect that portion of the Trust with respect to each Participant and with respect to each Employer (regarding its contributions which have not been allocated to Participant Accounts), and the contributions, income, losses, increases and decreases for expenses or benefit payments, transfers and adjustments attributable to each such account. The Trustees shall not be required to maintain separate investments for any account.

4.2 Receipt of Contributions or Transfers. Contributions or transfers for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Trustees consistent with Participant investment elections. If any portion of any Plan contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Employer, or if a Participant Enrollment Form is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to a non-interest-bearing account for unallocated funds until such time as further instructions are received from the Employer, or the Administrator may return such contribution to the Employer. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior qualified plan on behalf of an Employee for whom an Enrollment Form is not submitted will not be returned to the Employer and will be treated as directed by the Employer in writing and in accordance with the policies and procedures established by the Trustees or Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 FIRST, allocate and credit any Employer contribution or transfer to this Plan that is made during the month to a Participant Account or Employer Account. Investment earnings or losses will accrue from the date the contribution or transfer is credited to a Participant Account or Employer Account, and funds will be invested as directed by the Participant or Employer in accordance with the policies and procedures of the Administrator, and investment earnings or losses will accrue from the date the contribution or transfer is credited to the Participant Account or Employer Account in accordance with the policies and procedures of the Administrator;

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

4.3.3 THIRD, charge to each Participant Account and Employer Account all fees, payments, transfers, adjustments, or distributions made under this Plan to or for the benefit of the Participant or his Dependents, or the Employer, as the case may be, that have not been charged previously.

4.4 Use of Employer Accounts. Funds within each Employer Account are, at the direction of the Employer, either to be allocated to Participant Accounts or to be applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

Article V.
Qualified Health Care Benefits

5.1 Qualified Health Care Benefits. Subject to the limitations under Section 1.3, Qualified Health Care Benefits must be a reimbursement for medical care expenses as defined by IRC § 213(d) and excludable from income under IRC §§ 105 and 106, as amended from time to time. Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan, and reimbursements may not be made for items paid or payable by any other insurance contract or plan, 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. Reimbursement may be made for premiums due for any part of Medicare.

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

5.1.1 Expenses of Participant or Dependent(s). Qualified Health Care Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s).

5.1.2 Claims for Benefits. Participants may file claims for Qualified Health Care Benefits on or after the date they become a Participant, provided the Third-party Administrator has received a properly completed Participant Enrollment Form, a contribution or transfer on behalf of the Participant and any additional information that, in the discretion of the Third-party Administrator, is required or necessary for the Plan or Third-party Administrator to comply with applicable law, including without limitation, the reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP

Extension Act of 2007 (MMSEA). Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.3 Payment of Benefits. Qualified Health Care Benefits shall include (but are not limited to) premiums reimbursed directly to the Participant. Payment or reimbursement of Qualified Health Care Benefits shall be made in accordance with rules, regulations and limitations established by the Trustees from time to time consistent with the requirements of the Internal Revenue Code.

5.2 Termination of Benefits. All Benefits for any Participant will terminate as of the date when such Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

5.3 Dependent Health Care Benefits in the Event of Death. After the death of a Participant and if no Dependents remain eligible for Qualified Health Care Benefits, any vested funds then remaining in the deceased Participant's Participant Account shall be forfeited and applied as provided in Section 5.4.

5.4 Forfeiture of Participant Account Balance. In the event any funds within a Participant Account are forfeited in accordance with the terms of the Plan documents, such forfeited funds shall be applied as follows, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator:

5.4.1 If such forfeiture occurs before January 1, 2014, such forfeited funds shall be reallocated in equal amounts to all Participants of the deceased or forfeiting Participant's Employer within the Trust that have a positive balance at the time of such reallocation.

5.4.2 If such forfeiture occurs on or after January 1, 2014, such forfeited funds shall be transferred to a temporary forfeiture account held within the Trust on behalf of all Participants of the deceased or forfeiting Participant's Employer within the Trust, to be re-contributed as future contributions to Participants eligible for contributions or otherwise applied, as directed by the Employer.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to one or more surviving Dependents for Benefits under the Plan in the event of the Participant's death, shall be limited (in the aggregate) to the balance in such Participant's Participant Account. None of the Employer, Trustees or Third-party Administrator, or any of their agents, subcontractors, representatives, officers, or employees shall be responsible for any Benefits under the Plan.

6.2 Investment of Participant Accounts and Employer Accounts. The Trustees shall determine the options to be made available through the Trust for the investment of Participant Accounts and Employer Accounts. For each Participant Account, the Participant shall elect one or more of the investment options into which the funds in such Participant Account will be allocated. For each Employer Account, the Employer (or a qualified investment manager appointed by the Employer) shall elect one or more of the investment options into which the funds in such Employer account will be allocated. Participant and Employer Account elections shall be made and changed in accordance with procedures established by the Trustees and as may be amended from time to time. In the event no election has been made with respect to a Participant Account or Employer Account, such Account shall be invested in one or more options whose investment objective is stable value. Separate investments shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts.

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

6.3.1 To reimburse Benefits for premium amounts paid to an insurance company, health benefit plan, HMO or PPO for qualified insurance premiums, including COBRA or qualified long-term care premiums; or

6.3.2 To reimburse Benefits for Qualified Health Care Benefits; or

6.3.3 To reimburse out-of-pocket premium expenses for Medicare coverage.

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

6.4.1 If the Claimant's request for benefits is approved by the Third-party Administrator, it shall notify the Claimant of such approval and distribute such benefits to the Claimant.

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

6.4.3 If the Claimant's request for benefits is denied, in whole or in part, by the Third-party Administrator, the Third-party Administrator shall notify the Claimant of

such denial and shall include in such notice, set forth in a manner calculated to be understood by the Claimant, the following:

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

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

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

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

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for Benefits is not received by the Claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, the request shall be deemed denied as of that date.

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

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

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

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

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

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

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

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

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

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

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

Once the review above is complete, the Third-party Administrator has one (1) business day to notify the Claimant in writing of the outcome of its review. If Claimant is not eligible for external review, the notice must include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If the Claimant’s request for external review was incomplete, the notice must describe

materials needed to complete the request and provide the later of 48 hours or the four-month filing period to complete the filing.

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

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

6.5 Mechanics of Payment from Employer Accounts. The Employer, or its agent or authorized officer, may submit a request to the Third-party Administrator to transfer funds from the Employer's Account to be allocated to Participant Accounts or applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

6.6 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).

6.6.1 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:

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

6.6.1.2 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;

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

6.6.1.4 report to the Privacy Official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.6.1.5 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;

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

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

6.7 Employer Uses of Protected Health Information.

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

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

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

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

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

"Privacy Official" means the Vice Chairman of the Board of Trustees or such other person appointed from time to time by the Board of Trustees to serve in such capacity.

An Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA.

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

Enrollment and disenrollment information shall include, without limitation, name, 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 acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

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

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

6.7.4 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 6.7.5 and obtaining written certification pursuant to Section 6.7.8, the Plan may disclose PHI and Electronic PHI to an Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

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

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

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

6.7.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan

Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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) disclosed to it by the Plan, such Employer shall:

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

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

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

6.7.5.4 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;

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

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

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

6.7.5.8 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;

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

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

6.7.6 Additional Requirements. Each Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8

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 who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

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

6.7.7 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 that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

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

6.7.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to an Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 6.7.5 and all other conditions and requirements of this HIPAA Plan Amendment.

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Article VII.
Administrator

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

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

7.1.2 To determine entitlement to Benefits under the provisions of Article VI.

7.1.3 To compute and certify to the Trustees the amount and kind of benefits payable to the Participants and their Dependents.

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

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

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

7.1.7 To facilitate the investment elections made by Participants and Employer in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

7.1.9 To inform the Trustees with respect to the investment of Participant and Employer Accounts.

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

7.2 Information. To enable the Third-party Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions on behalf of a Participant and Participant entitlement to benefits. The Employer shall also supply the Third-party Administrator with full and timely information on all matters relating to Employer contributions to an Employer Account. The Third-party Administrator shall maintain such information and advise the Trustees of such other information as may be pertinent to the Trustees' administration of the Trust.

The Third-party Administrator shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action for the purpose of performing its duties under the Plan or the Trust, and the Third-party Administrator shall have the right to rely on information provided by the Employer pursuant to

this section with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action.

7.2.1 The Trust shall provide to each Participant, information necessary to use their Participant Account and receive reimbursement of Benefits. The information will include a summary of the Plan, including claim procedures and instructions on how to acquire plan forms. The Trust shall also communicate within a reasonable amount of time after receipt of the contribution or transfer an acknowledgement to the Participant with a Participant Account or the Employer with an Employer Account, whichever is applicable, acknowledging establishment of the Participant Account or Employer Account; confirmation of the amount received; a summary of the Plan and information on filing claims with copies of the necessary forms, if applicable; and a toll-free contact telephone number for error corrections or questions.

7.2.2 The Trust shall provide a written statement prepared upon a Participant's or Employer's request, and at least semi-annually for each Participant and Employer, which shall include the following information: Participant's or Employer's name and address, whichever is applicable; Participant Account number; contributions; total Account value at statement date; interest earned or other shared gain or loss; payout and disbursement activities, ending/forward balance; toll-free contact telephone number for error corrections or questions on reading the statement.

7.2.3 The Trust shall provide a monthly unaudited report to the Trustees including the following: income statement, balance sheet, year to date budget, number of Participant Accounts, and other such reports which are permitted by law, the Trustees and/or Employer requests and agreed to by the Plan Third-party Administrator.

7.3 Compensation, Expenses, and Governmental Fees, Taxes and Assessments. Consultant and investment manager expenses for the Plan may be paid by reasonable reductions of investment earnings and/or assessments from the Participants' Accounts as determined by the Trustees from time to time. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, plan administration software or technology, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, the Trustees, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Trustees from time to time.

7.4 Consultants, Advisors & Managers. The Trustees may employ such consultants, advisors, investment managers, Third-party Administrators, and other service providers as they reasonably deem necessary or useful in carrying out their duties hereunder, all of which shall be considered expenses of administering the Plan.

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

7.6 Notices & Directions. The address for delivery of all communications shall be:

HRA VEBA Trust
c/o VEBA Service Group, a Division of Gallagher Benefit Services, Inc.
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4537
(509) 838-5571 Telephone
(509) 838-5613 Fax
mark_wilkerson@ajg.com

7.7 Funding Policy & Procedures. The Trustees shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employers and Trustees that this Plan, and the payment of Benefits hereunder, will be continued indefinitely, but continuance of this Plan or contributions to this Plan is not assumed as a contractual obligation of the Employers or the Trustees. This Plan may be amended or terminated only as provided in this Article.

8.2 Exclusive Benefit Rule. It shall be impossible for any part of the funds in Participant Accounts under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

8.3 Amendments.

8.3.1 The Trustees shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments.

8.3.2 Such amendments shall be as set forth in an instrument in writing executed by the Trustees. Any amendment may be current, retroactive, or prospective, in each case as provided therein and provided, however, that such amendment must comply with Article III of the Trust Agreement.

8.4 Discontinuance of Contributions. Each Employer shall have the right to discontinue contributions without prior notice by delivering written notice of termination to the Trustees.

8.5 Termination of Plan. The Trustees shall have the right to terminate this Plan without prior notice unless required by law by delivering written notice of termination to the Employers and Participants. In case of termination, the Trustees shall also notify the Employers and Participants of the Trustees' decision with regard to disposition of the assets, based on the following options, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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

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

8.5.3 An immediate cash payment to another IRC § 501(c)(9) trust or another program providing benefits permitted by IRC § 501(c)(9); or

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

In any event, the Employers and the Trustees shall work to prevent adverse consequences to Participants and other Employers contributing to the Trust as a result of any Employer's decision or action with respect to these options. An Employer whose Employer Account or whose Employees' Participant Accounts are to be transferred from the Trust agrees to pay the Trust all reasonable costs resulting from the disposition or transfer of the assets that are to be transferred.

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, the Employer Adoption Agreement, and the Participant Enrollment Form are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of this Plan and the Participant Enrollment Form, the Employer Adoption Agreement and the terms of the Trust, such conflict shall be resolved first by reference to the Trust, except as more specifically addressed in the Plan, then the Plan, then the Employer Adoption Agreement, then the Participant Enrollment Form.

9.2 Applicable Law; Severability. Except as required in § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), this Plan shall be construed, administered, and governed under the laws of the State of Washington. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

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

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

9.5 Forfeiture of Unclaimed Participant Accounts. The account balance in a Participant Account shall be forfeited and applied as provided in Section 5.4 if (a) within the Unclaimed Account Forfeiture Period (defined below) at least two communications from the Plan to the Participant have been returned as undeliverable and (b) during the entire Unclaimed Account Forfeiture Period, the following conditions exist:

9.5.1 Such Participant Account has a positive account balance and is claims-eligible;

9.5.2 No contributions to or withdrawals from the Participant Account have occurred; and

9.5.3 No communications or other expressions of interest have been received

by the Third-party Administrator from or on behalf of the Participant of such Participant Account.

For purposes of this Section 9.5, the "Unclaimed Account Forfeiture Period" shall be a continuous period that is equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for such Participant Account or (ii) three years.

9.6 Limitation on Rights. Neither the establishment of this Plan, nor any modification or amendment thereof, nor the payment of any Benefits, nor the issuance of any insurance contracts shall be construed as giving any Participant, or any person whomsoever, any legal or equitable right against the Trustees, the State of Washington, its agencies, officers, employees, and institutions of higher education, or the Employers or Administrator or Third-party Administrator or any of their agents or employees, nor any right to the assets of the Plan, except as expressly provided herein.

9.7 Assignment. The interest of any Participant or Employer in any assets held on his or its behalf by the Trustee shall not be subject to assignment or alienation, either by voluntary or involuntary act of the Participant or the Employer or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process, except to the extent required by law.

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

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IN WITNESS WHEREOF, Doug Detling, Chairman of the Board of Trustees, being duly authorized, on this 13th day of December, 2013 signed this Plan Document.

By: _____
Doug Detling, Chairman

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
POST-SEPARATION HEALTH CARE REIMBURSEMENT PLAN
FOR PUBLIC EMPLOYEES IN THE NORTHWEST

(FULL 213(d) MEDICAL BENEFITS COVERAGE)

Amended and Restated as of January 1, 2014

Article I.
General Provisions

1.1 Name. The name of this Plan is the VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION POST-SEPARATION HEALTH CARE REIMBURSEMENT PLAN FOR PUBLIC EMPLOYEES IN THE NORTHWEST ("HRA VEBA Post-separation HRA Plan" or "Plan"). It is offered by a voluntary employees' beneficiary association under Internal Revenue Code § 501(c)(9). The effective date for the Plan is July 1, 2013.

1.2 Plan Documents. This Plan document, together with the Trust Agreement, the individual Participant Enrollment Form, and the Employer Adoption Agreement shall constitute this entire Plan.

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

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

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

1.4.2 Application of Forfeitures. Any positive account balance that is waived and forfeited pursuant to this Section 1.4 shall be applied as provided in Section 5.4.

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

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

1.7 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Benefits as described in Section 5.1.

"Claims-Eligible" with respect to any Participant means that such Participant has satisfied the conditions required to become eligible for reimbursement of Qualified Health Care Benefits as described in Section 2.1.2.

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

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

"Employee" means any current or former employee of the Employer, as defined by Treasury Regulation § 1.501(c)(9)-2(b), except employees excluded as a result of collective bargaining agreements, agreements substantially similar to collective bargaining agreements, or as a result of an individual Employer's nondiscriminatory employer benefits policies.

"Employer" means a county, city, or town, or special purpose district, or similar entity in Washington, Oregon, and Idaho, whose purpose is to provide public services to its citizens, and is authorized to do so by state statute.

"Employer Account" refers to the account maintained with respect to any Employer to record its contributions which have not been allocated to Participant Accounts, and adjustments related thereto, and established for the purpose of providing benefits permitted under IRC § 501(c)(9).

"Employer Adoption Agreement" means an Employer Adoption Agreement executed by an Employer and accepted by the Trust, as the same may be amended and restated or replaced from time to time.

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

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

"Participant" means an Employee who has become eligible as a Participant as described in Article II.

"Participant Account" refers to the account maintained for a Participant to record his/her share of the contributions of the Employer and adjustments relating thereto.

"Participant Enrollment Form" means the form provided by the Plan that must be completed by the Employee in order to participate in this Plan.

"Plan Year" is from October 1 to September 30, except the first year for this Plan with an effective date other than October 1 shall run from such effective date until the next September 30.

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

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

"Qualified Health Care Benefits" 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 contributions into such Participant's Participant Account, that such Participant has become re-employed with such Employer under any circumstances.

"Third-party Administrator" means a third-party appointed or contracted by the Trustees from time to time to provide record-keeping, claims-payment and other plan administration services to all or a portion of the Trust or this Plan.

"Trust" or "Trust Agreement" refers to the Voluntary Employees' Beneficiary Association for Public Employees in the Northwest Trust and as it may be amended, restated, or replaced from time to time.

"Trustees" refers to the individuals serving as Trustees in accordance with the Trust.

Article II.
Participation

2.1 In General. Subject to the limitations of this Article II, and subject to the eligibility provisions of applicable local and State law:

2.1.1 On the date that the Third-party Administrator has received both an Employer contribution to this Plan allocated to an Employee and a properly completed and signed Participant Enrollment Form, such Employee shall become eligible as a Participant in this Plan and shall have all of the rights of Participants described in this Plan, provided that, such Employee shall not be "Claims-Eligible" except as provided in Section 2.1.2 hereof.

2.1.2 A Participant described in Section 2.1.1 becomes "Claims-Eligible" under this Plan, and becomes eligible for reimbursement of Qualified Health Care Benefits under Article V, only upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements and the Employer Adoption Agreement or other Employer action or adoption procedure accepted by the Trust.

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

2.3 Duration of Participation.

2.3.1 Upon becoming a Participant in the Plan, an Employee's status as a Participant shall continue for as long as the Participant has a positive balance in any Participant Account. In addition, Participant status shall continue for forty-five (45) days during which all Participant Accounts for such Participant remain exhausted. If all Participant Accounts for such Participant remain exhausted for forty-five (45) days and the Third-party Administrator has not received notice from the Employer that additional funds will be added to any of such Participant Accounts, then the Employee's status as a Participant and eligibility to file claims for reimbursement of Qualified Health Care Benefits shall temporarily terminate on the first day immediately after such 45-day period. If a contribution or transfer is subsequently received into any Participant Account for such Participant before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be restored back to the original effective date of such Participant Account, and such Participant shall be eligible to file claims for expenses incurred during the period his or her Participant status was temporarily terminated, provided that such Participant would have otherwise been Claims-Eligible during such period. If a contribution or transfer is not received into such Participant Account before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be permanently terminated as of the end of such second Plan Year. An eligible Employee who has permanently lost his or her status as a Participant at the end of the second consecutive Plan Year may subsequently become eligible as a Participant and Claims-Eligible as prescribed in Section 2.1.

2.3.2 If, after a Participant becomes Claims-Eligible as described in Section 2.1.2 (upon separation from service from the Employer), such Participant becomes Re-employed by the same Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Qualified Health Care Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Qualified Health Care Benefits incurred thereafter.

Article III.
Funding of Benefits

3.1 Contributions. Each Employer shall contribute or transfer assets to this Plan on behalf of its Employees on terms pursuant to collective bargaining agreements, other written agreements, or Employer benefits policies, whichever is applicable. Employer contributions or transfers shall be specifically allocated to one or more Participant Accounts or to an Employer Account for the purpose of providing for payment of the Benefits described hereinafter or maintained in an Employer Account, as directed by the Employer. The liabilities, expenses, costs and charges associated with each particular Participant and Employer Account shall be charged against the assets of the Trust held with respect to that particular Participant or Employer Account.

Article IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Third-party Administrator to reflect that portion of the Trust with respect to each Participant and with respect to each Employer (regarding its contributions which have not been allocated to Participant Accounts), and the contributions, income, losses, increases and decreases for expenses or benefit payments, transfers and adjustments attributable to each such account. The Trustees shall not be required to maintain separate investments for any account.

4.2 Receipt of Contributions or Transfers. Contributions or transfers for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Trustees consistent with Participant investment elections. If any portion of any Plan contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Employer, or if a Participant Enrollment Form is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to a non-interest-bearing account for unallocated funds until such time as further instructions are received from the Employer, or the Administrator may return such contribution to the Employer. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior qualified plan on behalf of an Employee for whom an Enrollment Form is not submitted will not be returned to the Employer and will be treated as directed by the Employer in writing and in accordance with the policies and procedures established by the Trustees or Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 FIRST, allocate and credit any Employer contribution or transfer to this Plan that is made during the month to a Participant Account or Employer Account.

Investment earnings or losses will accrue from the date the contribution or transfer is credited to a Participant Account or Employer Account, and funds will be invested as directed by the Participant or Employer in accordance with the policies and procedures of the Administrator, and investment earnings or losses will accrue from the date the contribution or transfer is credited to the Participant Account or Employer Account in accordance with the policies and procedures of the Administrator;

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

4.3.3 THIRD, charge to each Participant Account and Employer Account all fees, payments, transfers, adjustments, or distributions made under this Plan to or for the benefit of the Participant or his Dependents, or the Employer, as the case may be, that have not been charged previously.

4.4 Use of Employer Accounts. Funds within each Employer Account are, at the direction of the Employer, either to be allocated to Participant Accounts or to be applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

Article V.
Qualified Health Care Benefits

5.1 Qualified Health Care Benefits. Qualified Health Care Benefits must be a reimbursement for medical care expenses as defined by IRC § 213(d) and excludable from income under IRC §§ 105 and 106, as amended from time to time. Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan, and reimbursements may not be made for items paid or payable by any other insurance contract or plan, for expenses that are deducted by the Participant under any section of the Internal Revenue Code, or for expenses which were incurred prior to becoming Claims-Eligible or during any period of Re-employment. Reimbursement may be made for premiums due for any part of Medicare.

A "Limited HRA VEBA Plan Coverage" option may be available to Claims-Elgible Participants who desire to limit their Qualified Health Care Benefits to coordinate with the Participant's other benefit plans. Such Limited HRA VEBA Plan Coverage shall be subject to the limitations and provisions of applicable law and in accordance with rules, regulations and limitations established by the Trustees from time to time. Limited HRA VEBA Plan Coverage constitutes minimum essential coverage, as defined under IRC § 5000A, and will not be effective to enable a Participant to become potentially eligible for an IRC § 36B premium tax credit. To become eligible for an IRC § 36B premium tax credit, a Participant must make a forfeiture election under Section 1.4 or elect Pre-Medicare Limited-Scope coverage under Section 1.5.

Claims-Eligible Participants who are covered by an IRC § 125 healthcare flexible spending account which provides benefits covered under this Plan must exhaust benefits under the IRC § 125 plan prior to filing a request for reimbursement of Qualified Health Care Benefits under this Plan.

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

5.1.2 Claims for Benefits. Participants may file claims for Qualified Health Care Benefits on or after the date they become Claims-Eligible, provided the Third-party Administrator has received any information that, in the discretion of the Third-party Administrator, is required or necessary for the Plan or Third-party Administrator to comply with applicable law. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer who made contributions on behalf of such Participant. Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.3 Payment of Benefits. Qualified Health Care Benefits shall include (but are not limited to) premiums reimbursed directly to the Participant. Payment or reimbursement of Qualified Health Care Benefits shall be made in accordance with rules, regulations and limitations established by the Trustees from time to time consistent with the requirements of the Internal Revenue Code. Payment or reimbursement of Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

5.2 Termination of Benefits. All Benefits for any Participant will terminate as of the date when such Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

5.3 Dependent Health Care Benefits in the Event of Death. After the death of a Participant and if no Dependents remain eligible for Qualified Health Care Benefits, any vested funds then remaining in the deceased Participant's Participant Account shall be forfeited and applied as provided in Section 5.4.

5.4 Forfeiture of Participant Account Balance. In the event any funds within a Participant Account are forfeited in accordance with the terms of the Plan documents, such forfeited funds shall be applied as follows, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator:

5.4.1 If such forfeiture occurs before January 1, 2014, such forfeited funds shall be reallocated in equal amounts to all Participants of the deceased or forfeiting Participant's Employer within the Trust that have a positive balance at the time of such reallocation.

5.4.2 If such forfeiture occurs on or after January 1, 2014, such forfeited funds shall be transferred to a temporary forfeiture account held within the Trust on behalf of all Participants of the deceased or forfeiting Participant's Employer within the Trust, to be re-contributed as future contributions to Participants eligible for contributions or otherwise applied, as directed by the Employer.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to one or more surviving Dependents for Benefits under the Plan in the event of the Participant's death, shall be limited (in the aggregate) to the balance in such Participant's Participant Account. None of the Employer, Trustees or Third-party Administrator, or any of their agents, subcontractors, representatives, officers, or employees shall be responsible for any Benefits under the Plan.

6.2 Investment of Participant Accounts and Employer Accounts. The Trustees shall determine the options to be made available through the Trust for the investment of Participant Accounts and Employer Accounts. For each Participant Account, the Participant shall elect one or more of the investment options into which the funds in such Participant Account will be allocated. For each Employer Account, the Employer (or a qualified investment manager appointed by the Employer) shall elect one or more of the investment options into which the funds in such Employer account will be allocated. Participant and Employer Account elections shall be made and changed in accordance with procedures established by the Trustees and as may be amended from time to time. In the event no election has been made with respect to a Participant Account or Employer Account, such Account shall be invested in one or more options whose investment objective is stable value. Separate investments shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts.

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

6.3.1 To reimburse Qualified Health Care Benefits for premium amounts paid to an insurance company, health benefit plan, HMO or PPO for qualified insurance premiums, including qualified long-term care premiums; or

6.3.2 To reimburse Qualified Health Care Benefits for COBRA premium payments; or

6.3.3 To reimburse Qualified Health Care Benefits to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses;

6.3.4 To reimburse Medicare and Medicare supplement premiums.

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

6.4.1 If the Claimant's request for benefits is approved by the Third-party Administrator, it shall notify the Claimant of such approval and distribute such benefits to the Claimant.

6.4.2 In the event the Third-party Administrator determines that a claim is

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

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

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

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

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

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

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for Benefits is not received by the Claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, the request shall be deemed denied as of the date on which the Third-party Administrator's time period for rendering its decision expires.

6.4.5 Any Claimant whose request for Benefits has been denied or deemed denied, in whole or in part, or such Claimant's authorized representative, may appeal said denial of Plan benefits by submitting to the Third-party Administrator a written request for a review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than one hundred eighty (180) days from the date the Claimant received written notification of the Third-party Administrator's initial denial of the Claimant's request for Benefits or from the date the claim was deemed denied, unless

the Third-party Administrator, upon the written application of the Claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

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

6.4.7 Upon receiving a request by a Claimant, or his authorized representative, for a review of a denied claim, the Third-party Administrator shall deliver the complete file to the Trustees, who shall consider such request promptly and shall advise the Claimant of their decision within thirty (30) days from the date on which said request for review was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said denied claim. In the event special circumstances require an extension of time for reviewing said denied claim, the Third-party Administrator shall, prior to the expiration of the initial 30-day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Trustees expect to render their decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the Claimant's request for review was received by the Third-party Administrator. The Trustees' decision shall be furnished to the Claimant and shall:

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

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

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

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

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

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

6.4.9 After exhausting the above claims procedures in full, any Claimant whose request for benefits has been denied or deemed denied, in whole or in part, or such

Claimant's authorized representative, may file a request for an external review of such denied claim. Any such request for review must be delivered to the Third-party Administrator no later than the first day of the fifth month following the date the Claimant received written notification of the Trustees' final denial of the Claimant's request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the Third-party Administrator must complete a preliminary review to determine if the Claimant was covered under the Plan, the Claimant provided all the information and forms necessary to process the external review, and the Claimant has exhausted the internal appeals process.

Once the review above is complete, the Third-party Administrator has one (1) business day to notify the Claimant in writing of the outcome of its review. If Claimant is not eligible for external review, the notice must include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If the Claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four-month filing period to complete the filing.

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

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

6.5 Mechanics of Payment from Employer Accounts. The Employer, or its agent or authorized officer, may submit a request to the Third-party Administrator to transfer funds from the Employer's Account to be allocated to Participant Accounts or applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

6.6 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).

6.6.1 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:

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

6.6.1.2 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;

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

6.6.1.4 report to the Privacy Official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.6.1.5 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;

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

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

6.7 Employer Uses of Protected Health Information.

6.7.1 HIPAA Plan Amendment. Members of the workforce of an Employer 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, 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 6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

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

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

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

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

"Privacy Official" means the Vice Chairman of the Board of Trustees or such other person appointed from time to time by the Board of Trustees to serve in such capacity.

An Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA.

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

Enrollment and disenrollment information shall include, without limitation, name, 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 acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

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

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

6.7.4 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 6.7.5 and obtaining written certification pursuant to Section 6.7.8, the Plan may disclose PHI and Electronic PHI to an Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

6.7.4.1 *"Plan Administration Purposes"* means administration functions performed by the Employer on behalf of the Plan, such as quality assurance,

claims processing and appeals, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer or any employment-related actions or decisions.

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

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

6.7.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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) disclosed to it by the Plan, such Employer shall:

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

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

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

6.7.5.4 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;

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

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

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

6.7.5.8 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;

6.7.5.9 if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information

when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

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

6.7.6 Additional Requirements. Each Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

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

6.7.7 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 that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

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

6.7.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to an Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been drafted to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 6.7.5 and all other conditions and requirements of this HIPAA Plan Amendment.

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Article VII.
Administrator

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

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

7.1.2 To determine entitlement to Benefits under the provisions of Article VI.

7.1.3 To compute and certify to the Trustees the amount and kind of benefits payable to the Participants and their Dependents.

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

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

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

7.1.7 To facilitate the investment elections made by Participants and Employer in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

7.1.9 To inform the Trustees with respect to the investment of Participant and Employer Accounts.

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

7.2 Information. To enable the Third-party Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions on behalf of Participants and Participant entitlement to benefits. The Employer shall also supply the Third-party Administrator with full and timely information on all matters relating to Employer contributions to an Employer Account. The Third-party Administrator shall maintain such information and advise the Trustees of such other information as may be pertinent to the Trustees' administration of the Trust.

The Third-party Administrator shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action for the purpose of performing its duties under the Plan or the Trust, and the Third-party Administrator shall have the right to rely on information provided by the Employer pursuant to

this section with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action.

7.2.1 The Trust shall provide to each Participant, information necessary to use their Participant Account and receive reimbursement of Benefits. The information will include a summary of the Plan, including claim procedures and instructions on how to acquire plan forms. The Trust shall also communicate within a reasonable amount of time after receipt of the contribution or transfer an acknowledgement to the Participant with a Participant Account or the Employer with an Employer Account, whichever is applicable, acknowledging establishment of the Participant Account or Employer Account; confirmation of the amount received; a summary of the Plan and information on filing claims with copies of the necessary forms, if applicable; and a toll-free contact telephone number for error corrections or questions.

7.2.2 The Trust shall provide a written statement prepared upon a Participant's or Employer's request, and at least semi-annually for each Participant and Employer, which shall include the following information: Participant's or Employer's name and address, whichever is applicable; Participant Account number; contributions; total Account value at statement date; interest earned or other shared gain or loss; payout and disbursement activities, ending/forward balance; toll-free contact telephone number for error corrections or questions on reading the statement.

7.2.3 The Trust shall provide a monthly unaudited report to the Trustees including the following: income statement, balance sheet, year to date budget, number of Participant Accounts, and other such reports which are permitted by law, the Trustees and/or Employer requests and agreed to by the Plan Third-party Administrator.

7.3 Compensation, Expenses, and Governmental Fees, Taxes and Assessments. Consultant and investment manager expenses for the Plan may be paid by reasonable reductions of investment earnings and/or assessments from the Participants' Accounts as determined by the Trustees from time to time. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, plan administration software or technology, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, the Trustees, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Trustees from time to time.

7.4 Consultants, Advisors & Managers. The Trustees may employ such consultants, advisors, investment managers, Third-party Administrators, and other service providers as they reasonably deem necessary or useful in carrying out their duties hereunder, all of which shall be considered expenses of administering the Plan.

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

7.6 Notices & Directions. The address for delivery of all communications shall be:

HRA VEBA Trust
c/o VEBA Service Group, a Division of Gallagher Benefit Services, Inc.
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4537
(509) 838-5571 Telephone
(509) 838-5613 Fax
1-800-888-8322 Toll-free
mark_wilkerson@ajg.com

7.7 Funding Policy & Procedures. The Trustees shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employers and Trustees that this Plan, and the payment of Benefits hereunder, will be continued indefinitely, but continuance of this Plan or contributions to this Plan is not assumed as a contractual obligation of the Employers or Trustees. This Plan may be amended or terminated only as provided in this Article.

8.2 Exclusive Benefit Rule. It shall be impossible for any part of the funds in Participant Accounts under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

8.3 Amendments.

8.3.1 The Trustees shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments.

8.3.2 Such amendments shall be as set forth in an instrument in writing executed by the Trustees. Any amendment may be current, retroactive, or prospective, in each case as provided therein and provided, however, that such amendment must comply with Article III of the Trust Agreement.

8.4 Discontinuance of Contributions. Each Employer shall have the right to discontinue contributions without prior notice by delivering written notice of termination to the Trustees.

8.5 Termination of Plan. The Trustees shall have the right to terminate this Plan without prior notice unless required by law by delivering written notice of termination to the Employers and Participants. In case of termination, the Trustees shall also notify the Employers and Participants of the Trustees' decision with regard to disposition of the assets, based on the following options, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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

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

8.5.3 An immediate cash payment to another IRC § 501(c)(9) trust or another program providing benefits permitted by IRC § 501(c)(9); or

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

In any event, the Employers and the Trustees shall work to prevent adverse consequences to Participants and other Employers contributing to the Trust as a result of any Employer's decision or action with respect to these options. An Employer whose Employer Account or whose Participants' Participant Accounts are to be transferred from the Trust agrees to pay the Trust all reasonable costs resulting from the disposition or transfer of the assets that are to be transferred.

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, the Employer Adoption Agreement, and the Participant Enrollment Form are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of this Plan and the Participant Enrollment Form, the Employer Adoption Agreement and the terms of the Trust, such conflict shall be resolved first by reference to the Trust, except as more specifically addressed in the Plan, then the Plan, then the Employer Adoption Agreement, then the Participant Enrollment Form.

9.2 Applicable Law; Severability. Except as required in § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), this Plan shall be construed, administered, and governed under the laws of the State of Washington. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

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

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

9.5 Forfeiture of Unclaimed Participant Accounts. The account balance in a Participant Account shall be forfeited and applied as provided in Section 5.4 if (a) within the Unclaimed Account Forfeiture Period (defined below) at least two communications from the Plan to the Participant have been returned as undeliverable and (b) during the entire Unclaimed Account Forfeiture Period, the following conditions exist:

9.5.1 Such Participant Account has a positive account balance and is claims-eligible;

9.5.2 No contributions to or withdrawals from the Participant Account have

occurred; and

9.5.3 No communications or other expressions of interest have been received by the Third-party Administrator from or on behalf of the Participant of such Participant Account.

For purposes of this Section 9.5, the "Unclaimed Account Forfeiture Period" shall be a continuous period that is equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for such Participant Account or (ii) three years.

9.6 Limitation on Rights. Neither the establishment of this Plan, nor any modification or amendment thereof, nor the payment of any Benefits, nor the issuance of any insurance contracts shall be construed as giving any Participant, or any person whomsoever, any legal or equitable right against the Trustees, the State of Washington, its agencies, officers, employees, and institutions of higher education, or the Employers or Administrator or Third-party Administrator or any of their agents or employees, nor any right to the assets of the Plan, except as expressly provided herein.

9.7 Assignment. The interest of any Participant or Employer in any assets held on his or its behalf by the Trustee shall not be subject to assignment or alienation, either by voluntary or involuntary act of the Participant or Employer or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process, except to the extent required by law.

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

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IN WITNESS WHEREOF, Doug Detling, Chairman of the Board of Trustees, being duly authorized, on this 19th day of December, 2013 signed this Plan Document.

By: _____
Doug Detling, Chairman

VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION
POST-SEPARATION HEALTH CARE REIMBURSEMENT PLAN
FOR PUBLIC EMPLOYEES IN THE NORTHWEST

(PRE-MEDICARE LIMITED SCOPE COVERAGE)

Amended and Restated as of January 1, 2014

Article I.
General Provisions

1.1 Name. The name of this Plan is the VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION POST-SEPARATION HEALTH CARE REIMBURSEMENT PLAN FOR PUBLIC EMPLOYEES IN THE NORTHWEST ("HRA VEBA Post-separation HRA Plan" or "Plan"). It is offered by a voluntary employees' beneficiary association under Internal Revenue Code § 501(c)(9). The effective date for the Plan is July 1, 2013.

1.2 Plan Documents. This Plan document, together with the Trust Agreement, the individual Participant Enrollment Form, and the Employer Adoption Agreement shall constitute this entire Plan.

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

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

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

1.4.2 Full 213(d) Medical Benefits after Medicare-eligibility. After the earlier to occur of (i) the Participant's eligibility for Medicare due to age or permanent disability or (ii) the Participant's death, the Pre Medicare Limited Scope Coverage under Section 1.3.1 may be terminated, and benefits for medical expenses incurred by such Participant and his or her Dependents after the date of such termination of Pre-Medicare Limited Scope Coverage shall include reimbursement for any expense that constitutes a Qualified Health Care Benefit.

1.5 Interpretation of Capitalized Terms. Capitalized terms used herein and not otherwise defined in this document, shall have the meanings ascribed to such terms in the other

Plan documents. In the event there is a conflict in the definition ascribed to any term in two or more Plan documents, Plan forms, or other Plan materials, the definition ascribed to such term within any particular document shall apply for interpretation of that document, and if not defined therein, the meaning that shall apply for interpretation of a document shall be determined by reference first to the Trust, second to the Plan, third to the applicable Employer Adoption Agreement, and fourth to the applicable Participant Enrollment Form.

1.6 Definitions.

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

"Benefits" refers to reimbursements for or payments of Qualified Health Care Benefits as described in Section 5.1.

"Claims-Eligible" with respect to any Participant means that such Participant has satisfied the conditions required to become eligible for reimbursement of Qualified Health Care Benefits as described in Section 2.1.2.

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

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

"Employee" means any current or former employee of the Employer, as defined by Treasury Regulation § 1.501(c)(9)-2(b), except employees excluded as a result of collective bargaining agreements, agreements substantially similar to collective bargaining agreements, or as a result of an individual Employer's nondiscriminatory employer benefits policies.

"Employer" means a county, city, or town, or special purpose district, or similar entity in Washington, Oregon, and Idaho, whose purpose is to provide public services to its citizens, and is authorized to do so by state statute.

"Employer Account" refers to the account maintained with respect to any Employer to record its contributions which have not been allocated to Participant Accounts, and adjustments related thereto, and established for the purpose of providing benefits permitted under IRC § 501(c)(9).

"Employer Adoption Agreement" means an Employer Adoption Agreement executed by an Employer and accepted by the Trust, as the same may be amended and restated or replaced from time to time.

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

"Participant" means an Employee who has become eligible as a Participant as described in Article II.

"Participant Account" refers to the account maintained for a Participant to record his/her share of the contributions of the Employer and adjustments relating thereto.

"Participant Enrollment Form" means the form provided by the Plan that must be completed by the Employee in order to participate in this Plan.

"Plan Year" is from October 1 to September 30, except the first year for this Plan with an effective date other than October 1 shall run from such effective date until the next September 30.

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

"Qualified Health Care Benefits" 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 contributions into such Participant's Participant Account, that such Participant has become re-employed with such Employer under any circumstances.

"Third-party Administrator" means a third-party appointed or contracted by the Trustees from time to time to provide record-keeping, claims-payment and other plan administration services to all or a portion of the Trust or this Plan.

"Trust" or "Trust Agreement" refers to the Voluntary Employees' Beneficiary Association for Public Employees in the Northwest Trust and as it may be amended, restated, or replaced from time to time.

"Trustees" refers to the individuals serving as Trustees in accordance with the Trust.

Article II.
Participation

2.1 In General. Subject to the limitations of this Article II, and subject to the eligibility provisions of applicable local and State law:

2.1.1 On the date that the Third-party Administrator has received both an Employer contribution to this Plan allocated to an Employee and a properly completed and signed Participant Enrollment Form, such Employee shall become eligible as a Participant in this Plan and shall have all of the rights of Participants described in this Plan, provided that, such Employee shall not be "Claims-Eligible" except as provided in Section 2.1.2 hereof.

2.1.2 A Participant described in Section 2.1.1 becomes "Claims-Eligible" under this Plan, and becomes eligible for reimbursement of Qualified Health Care Benefits under Article V, only upon the Participant's retirement from employment or other separation from service with the Employer and upon satisfaction of any other eligibility provisions of Employer policies and applicable collective bargaining agreements and the Employer Adoption Agreement or other Employer action or adoption procedure accepted by the Trust.

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

2.3 Duration of Participation.

2.3.1 Upon becoming a Participant in the Plan, an Employee's status as a Participant shall continue for as long as the Participant has a positive balance in any Participant Account. In addition, Participant status shall continue for forty-five (45) days during which all Participant Accounts for such Participant remain exhausted. If all Participant Accounts for such Participant remain exhausted for forty-five (45) days and the Third-party Administrator has not received notice from the Employer that additional funds will be added to any of such Participant Accounts, then the Employee's status as a Participant and eligibility to file claims for reimbursement of Qualified Health Care Benefits shall temporarily terminate on the first day immediately after such 45-day period. If a contribution or transfer is subsequently received into any Participant Account for such Participant before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be restored back to the original effective date of such Participant Account, and such Participant shall be eligible to file claims for expenses incurred during the period his or her Participant status was temporarily terminated, provided that such Participant would have otherwise been Claims-Eligible during such period. If a contribution or transfer is not received into such Participant Account before the end of two (2) complete and consecutive Plan Years, then such Employee's status as a Participant shall be permanently terminated as of the end of such second Plan Year. An eligible Employee who has permanently lost his or her status as a Participant at the end of the second consecutive Plan Year may subsequently become eligible as a Participant and Claims-Eligible as prescribed in Section 2.1.

2.3.2 If, after a Participant becomes Claims-Eligible as described in Section 2.1.2 (upon separation from service from the Employer), such Participant becomes Re-employed by the same Employer, then the Re-employed Participant's status as Claims-Eligible shall terminate, at which time such Participant shall retain all the rights of Participants described in this Plan, except that, such Participant shall not be eligible for reimbursement of Qualified Health Care Benefits incurred during the term of such Re-employment. Such Participant shall become Claims-Eligible again upon subsequent retirement from employment or other separation from service with the Employer and shall be eligible for reimbursement of Qualified Health Care Benefits incurred thereafter.

Article III.
Funding of Benefits

3.1 Contributions. Each Employer shall contribute or transfer assets to this Plan on behalf of its Employees on terms pursuant to collective bargaining agreements, other written agreements, or Employer benefits policies, whichever is applicable. Employer contributions or transfers shall be specifically allocated to one or more Participant Accounts or to an Employer Account for the purpose of providing for payment of the Benefits described hereinafter or maintained in an Employer Account, as directed by the Employer. The liabilities, expenses, costs and charges associated with each particular Participant and Employer Account shall be charged against the assets of the Trust held with respect to that particular Participant or Employer Account.

Article IV.
Accounts

4.1 Participant Accounts and Employer Accounts. Accounting records shall be maintained by the Third-party Administrator to reflect that portion of the Trust with respect to each Participant and with respect to each Employer (regarding its contributions which have not been allocated to Participant Accounts), and the contributions, income, losses, increases and decreases for expenses or benefit payments, transfers and adjustments attributable to each such account. The Trustees shall not be required to maintain separate investments for any account.

4.2 Receipt of Contributions or Transfers. Contributions or transfers for any Plan Year will be credited as received by the Third-party Administrator and will be allocated as directed by the Trustees consistent with Participant investment elections. If any portion of any Plan contribution is not allocable to a specific Participant Account or an Employer Account pursuant to instructions from the Employer, or if a Participant Enrollment Form is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to a non-interest-bearing account for unallocated funds until such time as further instructions are received from the Employer, or the Administrator may return such contribution to the Employer. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior qualified plan on behalf of an Employee for whom an Enrollment Form is not submitted will not be returned to the Employer and will be treated as directed by the Employer in writing and in accordance with the policies and procedures established by the Trustees or Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall:

4.3.1 FIRST, allocate and credit any Employer contribution or transfer to this Plan that is made during the month to a Participant Account or Employer Account. Investment earnings or losses will accrue from the date the contribution or transfer is credited to a Participant Account or Employer Account, and funds will be invested as directed by the Participant or Employer in accordance with the policies and procedures of the Administrator, and investment earnings or losses will accrue from the date the contribution or transfer is credited to the Participant Account or Employer Account in accordance with the policies and procedures of the Administrator;

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

4.3.3 THIRD, charge to each Participant Account and Employer Account all fees, payments, transfers, adjustments, or distributions made under this Plan to or for the benefit of the Participant or his Dependents, or the Employer, as the case may be, that have not been charged previously.

4.4 Use of Employer Accounts. Funds within each Employer Account are, at the direction of the Employer, either to be allocated to Participant Accounts or to be applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

Article V.
Qualified Health Care Benefits

5.1 Qualified Health Care Benefits. Subject to the limitations under Section 1.4, Qualified Health Care Benefits must be a reimbursement for medical care expenses as defined by IRC § 213(d) and excludable from income under IRC §§ 105 and 106, as amended from time to time. Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan, and reimbursements may not be made for items paid or payable by any other insurance contract or plan, for expenses that are deducted by the Participant under any section of the Internal Revenue Code, or for expenses which were incurred prior to becoming Claims-Eligible or during any period of Re-employment. Reimbursement may be made for premiums due for any part of Medicare.

Claims-Eligible Participants who are covered by an IRC § 125 healthcare flexible spending account which provides benefits covered under this Plan must exhaust benefits under the IRC § 125 plan prior to filing a request for reimbursement of Qualified Health Care Benefits under this Plan.

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

5.1.2 Claims for Benefits. Participants may file claims for Qualified Health Care Benefits on or after the date they become Claims-Eligible, provided the Third-party Administrator has received any information that, in the discretion of the Third-party Administrator, is required or necessary for the Plan or Third-party Administrator to comply with applicable law. Reimbursements are not permitted for any expenses incurred prior to the date a Participant becomes Claims-Eligible or for expenses incurred during any period that a Participant is Re-employed with the Employer who made contributions on behalf of such Participant. Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.3 Payment of Benefits. Qualified Health Care Benefits shall include (but are not limited to) premiums reimbursed directly to the Participant. Payment or reimbursement of Qualified Health Care Benefits shall be made in accordance with rules, regulations and limitations established by the Trustees from time to time consistent with the requirements of the Internal Revenue Code. Payment or reimbursement of Benefits under this Plan shall be limited to expenses incurred only after a Participant has retired from employment or separated from service with his or her Employer and has otherwise met all other conditions for eligibility to become and remain a Participant hereunder and file claims for Benefits as set forth in any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer.

5.2 Termination of Benefits. All Benefits for any Participant will terminate as of the date when such Participant permanently loses his or her status as a Participant pursuant to Section 2.3.

5.3 Dependent Health Care Benefits in the Event of Death. After the death of a Participant and if no Dependents remain eligible for Qualified Health Care Benefits, any vested

funds then remaining in the deceased Participant's Participant Account shall be forfeited and applied as provided in Section 5.4.

5.4 Forfeiture of Participant Account Balance. In the event any funds within a Participant Account are forfeited in accordance with the terms of the Plan documents, such forfeited funds shall be applied as follows, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator:

5.4.1 If such forfeiture occurs before January 1, 2014, such forfeited funds shall be reallocated in equal amounts to all Participants of the deceased or forfeiting Participant's Employer within the Trust that have a positive balance at the time of such reallocation.

5.4.2 If such forfeiture occurs on or after January 1, 2014, such forfeited funds shall be transferred to a temporary forfeiture account held within the Trust on behalf of all Participants of the deceased or forfeiting Participant's Employer within the Trust, to be re-contributed as future contributions to Participants eligible for contributions or otherwise applied, as directed by the Employer.

Article VI.
Additional Plan Provisions

6.1 Source of Benefits. The Plan's obligation to any Participant for Benefits under the Plan, or to one or more surviving Dependents for Benefits under the Plan in the event of the Participant's death, shall be limited (in the aggregate) to the balance in such Participant's Participant Account. None of the Employer, Trustees or Third-party Administrator, or any of their agents, subcontractors, representatives, officers, or employees shall be responsible for any Benefits under the Plan.

6.2 Investment of Participant Accounts and Employer Accounts. The Trustees shall determine the options to be made available through the Trust for the investment of Participant Accounts and Employer Accounts. For each Participant Account, the Participant shall elect one or more of the investment options into which the funds in such Participant Account will be allocated. For each Employer Account, the Employer (or a qualified investment manager appointed by the Employer) shall elect one or more of the investment options into which the funds in such Employer account will be allocated. Participant and Employer Account elections shall be made and changed in accordance with procedures established by the Trustees and as may be amended from time to time. In the event no election has been made with respect to a Participant Account or Employer Account, such Account shall be invested in one or more options whose investment objective is stable value. Separate investments shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts.

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

6.3.1 To reimburse Qualified Health Care Benefits for premium amounts paid to an insurance company, health benefit plan, HMO or PPO for qualified insurance premiums, including qualified long-term care premiums; or

6.3.2 To reimburse Qualified Health Care Benefits for COBRA premium payments; or

6.3.3 To reimburse Qualified Health Care Benefits to a person requesting benefits in accordance with Section 6.4 for qualified medical expenses;

6.3.4 To reimburse Medicare and Medicare supplement premiums.

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

6.4.1 If the Claimant's request for benefits is approved by the Third-party Administrator, it shall notify the Claimant of such approval and distribute such benefits to the Claimant.

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

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

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

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

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

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

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

6.4.4 The Third-party Administrator shall provide written notice of a denial of a request for Benefits. In the event written notice of a denial of a request for Benefits is not received by the Claimant within forty-five (45) days of the date the written claim is submitted to the Third-party Administrator, the request shall be deemed denied as of the date on which the Third-party Administrator's time period for rendering its decision expires.

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

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

6.4.7 Upon receiving a request by a Claimant, or his authorized representative, for a review of a denied claim, the Third-party Administrator shall deliver the complete file to the Trustees, who shall consider such request promptly and shall advise the Claimant of their decision within thirty (30) days from the date on which said request for review was received by the Third-party Administrator, unless special circumstances require an extension of time for reviewing said denied claim. In the event special circumstances require an extension of time for reviewing said denied claim, the Third-party Administrator shall, prior to the expiration of the initial 30-day period referred to above, provide the Claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Trustees expect to render their decision. In no event shall such extension exceed a period of forty-five (45) days from the date on which the Claimant's request for review was received by the Third-party Administrator. The Trustees' decision shall be furnished to the Claimant and shall:

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

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

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

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

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

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

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

Once the review above is complete, the Third-party Administrator has one (1) business day to notify the Claimant in writing of the outcome of its review. If Claimant is not eligible for external review, the notice must include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If the Claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four-month filing period to complete the filing.

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

6.4.10 The claims procedures set forth in this Article VI shall be strictly adhered to by each Claimant under this Plan, and no judicial or arbitration proceedings with

respect to any claim for Plan benefits hereunder shall be commenced by any such Claimant until the proceedings set forth herein have been exhausted in full.

6.5 Mechanics of Payment from Employer Accounts. The Employer, or its agent or authorized officer, may submit a request to the Third-party Administrator to transfer funds from the Employer's Account to be allocated to Participant Accounts or applied in any manner permitted by IRC § 501(c)(9) and the Plan and Trust and in accordance with the rules, policies and procedures established by the Third-party Administrator.

6.6 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).

6.6.1 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:

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

6.6.1.2 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;

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

6.6.1.4 report to the Privacy Official any known use or disclosure that is inconsistent with permitted use and disclosures;

6.6.1.5 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;

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

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

6.7 Employer Uses of Protected Health Information.

6.7.1 HIPAA Plan Amendment. Members of the workforce of an Employer 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, 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 6.7 shall constitute the "HIPAA Plan Amendment" required by and incorporating the provisions of 45 CFR §164.504(f)(2)(ii).

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

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

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

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

"Privacy Official" means the Vice Chairman of the Board of Trustees or such other person appointed from time to time by the Board of Trustees to serve in such capacity.

An Employer shall have access to PHI and Electronic PHI from the Plan only as permitted under this HIPAA Plan Amendment or as otherwise required or permitted by HIPAA.

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

Enrollment and disenrollment information shall include, without limitation, name, 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 acknowledge and agree that enrollment and disenrollment information is information of the Employer and is held on behalf of the Employer by the Plan Third-party Administrator. Enrollment and disenrollment information held at any time by the Employer is held in its capacity as an Employer and is not PHI.

6.7.3 Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to an Employer, provided that the Employer requests the Summary Health Information for the purpose of (1) obtaining

premium bids from service providers or health plans for providing services or health coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

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

6.7.4 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 6.7.5 and obtaining written certification pursuant to Section 6.7.8, the Plan may disclose PHI and Electronic PHI to an Employer, provided that the Employer uses or discloses such PHI and Electronic PHI only for Plan Administration Purposes.

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

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

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

6.7.5 Conditions of Disclosure for Plan Administration Purposes. Each Employer agrees that with respect to any PHI it receives pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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) disclosed to it by the Plan, such Employer shall:

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

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

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

6.7.5.4 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;

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

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

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

6.7.5.8 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;

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

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

6.7.6 Additional Requirements. Each Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 who need the information for Plan Administration Purposes and employees of the Employer who do not need the information for Plan Administration Purposes or who do not perform Plan administration functions on behalf of the Employer, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

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

6.7.7 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 that receives any PHI pursuant to this HIPAA Plan Amendment and its HIPAA Compliance Certificate delivered pursuant to Section 6.7.8 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 HIPAA Compliance Certificate required by this HIPAA Plan Amendment. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Employer performs for the Plan. In the event that a specified employee does not comply with the provisions of this HIPAA Plan Amendment, the employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

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

6.7.8 Certification of Employer. The Plan shall disclose PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) to an Employer only upon the receipt of the Plan's HIPAA Compliance Certificate from the Employer acknowledging that the Plan has been drafted to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Employer agrees to the conditions of disclosure set forth in Section 6.7.5 and all other conditions and requirements of this HIPAA Plan Amendment.

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Article VII.
Administrator

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

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

7.1.2 To determine entitlement to Benefits under the provisions of Article VI.

7.1.3 To compute and certify to the Trustees the amount and kind of benefits payable to the Participants and their Dependents.

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

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

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

7.1.7 To facilitate the investment elections made by Participants and Employer in a manner consistent with the objectives of the Plan and authorized by the Trust.

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

7.1.9 To inform the Trustees with respect to the investment of Participant and Employer Accounts.

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

7.2 Information. To enable the Third-party Administrator to perform its functions, the Employer shall supply it with full and timely information on all matters relating to Employer contributions on behalf of Participants and Participant entitlement to benefits. The Employer shall also supply the Third-party Administrator with full and timely information on all matters relating to Employer contributions to an Employer Account. The Third-party Administrator shall maintain such information and advise the Trustees of such other information as may be pertinent to the Trustees' administration of the Trust.

The Third-party Administrator shall have neither the right nor the obligation to interpret the provisions of any collective bargaining agreement, Employer policy, or other statement or action for the purpose of performing its duties under the Plan or the Trust, and the Third-party Administrator shall have the right to rely on information provided by the Employer pursuant to

this section with respect to Employee eligibility and other applicable information contained in any collective bargaining agreement, Employer policy, or other statement or action.

7.2.1 The Trust shall provide to each Participant, information necessary to use their Participant Account and receive reimbursement of Benefits. The information will include a summary of the Plan, including claim procedures and instructions on how to acquire plan forms. The Trust shall also communicate within a reasonable amount of time after receipt of the contribution or transfer an acknowledgement to the Participant with a Participant Account or the Employer with an Employer Account, whichever is applicable, acknowledging establishment of the Participant Account or Employer Account; confirmation of the amount received; a summary of the Plan and information on filing claims with copies of the necessary forms, if applicable; and a toll-free contact telephone number for error corrections or questions.

7.2.2 The Trust shall provide a written statement prepared upon a Participant's or Employer's request, and at least semi-annually for each Participant and Employer, which shall include the following information: Participant's or Employer's name and address, whichever is applicable; Participant Account number; contributions; total Account value at statement date; interest earned or other shared gain or loss; payout and disbursement activities, ending/forward balance; toll-free contact telephone number for error corrections or questions on reading the statement.

7.2.3 The Trust shall provide a monthly unaudited report to the Trustees including the following: income statement, balance sheet, year to date budget, number of Participant Accounts, and other such reports which are permitted by law, the Trustees and/or Employer requests and agreed to by the Plan Third-party Administrator.

7.3 Compensation, Expenses, and Governmental Fees, Taxes and Assessments. Consultant and investment manager expenses for the Plan may be paid by reasonable reductions of investment earnings and/or assessments from the Participants' Accounts as determined by the Trustees from time to time. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, plan administration software or technology, Trustee, bank, consultant fees, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments applicable to the Trust, the Plan, the Trustees, or Participants, may be paid through a reduction of investment earnings and/or reasonable fees and assessments from Participant Accounts as determined by the Trustees from time to time.

7.4 Consultants, Advisors & Managers. The Trustees may employ such consultants, advisors, investment managers, Third-party Administrators, and other service providers as they reasonably deem necessary or useful in carrying out their duties hereunder, all of which shall be considered expenses of administering the Plan.

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

7.6 Notices & Directions. The address for delivery of all communications shall be:

HRA VEBA Trust
c/o VEBA Service Group, a Division of Gallagher Benefit Services, Inc.
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4537
(509) 838-5571 Telephone
(509) 838-5613 Fax
1-800-888-8322 Toll-free
mark_wilkerson@ajg.com

7.7 Funding Policy & Procedures. The Trustees shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and in accordance with applicable law.

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the Employers and Trustees that this Plan, and the payment of Benefits hereunder, will be continued indefinitely, but continuance of this Plan or contributions to this Plan is not assumed as a contractual obligation of the Employers or Trustees. This Plan may be amended or terminated only as provided in this Article.

8.2 Exclusive Benefit Rule. It shall be impossible for any part of the funds in Participant Accounts under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents, and to defray the reasonable expenses of administering the Trust and this Plan.

8.3 Amendments.

8.3.1 The Trustees shall have the right to amend this Plan from time to time, and to amend or cancel any such amendments.

8.3.2 Such amendments shall be as set forth in an instrument in writing executed by the Trustees. Any amendment may be current, retroactive, or prospective, in each case as provided therein and provided, however, that such amendment must comply with Article III of the Trust Agreement.

8.4 Discontinuance of Contributions. Each Employer shall have the right to discontinue contributions without prior notice by delivering written notice of termination to the Trustees.

8.5 Termination of Plan. The Trustees shall have the right to terminate this Plan without prior notice unless required by law by delivering written notice of termination to the Employers and Participants. In case of termination, the Trustees shall also notify the Employers and Participants of the Trustees' decision with regard to disposition of the assets, based on the following options, each of which shall be subject to any losses on or other contractual adjustments applicable to invested assets that may accrue or become due as a result of such disposition:

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

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

8.5.3 An immediate cash payment to another IRC § 501(c)(9) trust or another program providing benefits permitted by IRC § 501(c)(9); or

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

In any event, the Employers and the Trustees shall work to prevent adverse consequences to Participants and other Employers contributing to the Trust as a result of any Employer's decision or action with respect to these options. An Employer whose Employer Account or whose Participants' Participant Accounts are to be transferred from the Trust agrees to pay the Trust all reasonable costs resulting from the disposition or transfer of the assets that are to be transferred.

Article IX.
Miscellaneous

9.1 Conflicting Provisions. This Plan, the Trust, the Employer Adoption Agreement, and the Participant Enrollment Form are all parts of a single, integrated employee benefit system and shall be construed together. In the event of any conflict between the terms of this Plan and the Participant Enrollment Form, the Employer Adoption Agreement and the terms of the Trust, such conflict shall be resolved first by reference to the Trust, except as more specifically addressed in the Plan, then the Plan, then the Employer Adoption Agreement, then the Participant Enrollment Form.

9.2 Applicable Law; Severability. Except as required in § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), this Plan shall be construed, administered, and governed under the laws of the State of Washington. If any provision of this Plan shall be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

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

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

9.5 Forfeiture of Unclaimed Participant Accounts. The account balance in a Participant Account shall be forfeited and applied as provided in Section 5.4 if (a) within the Unclaimed Account Forfeiture Period (defined below) at least two communications from the Plan to the Participant have been returned as undeliverable and (b) during the entire Unclaimed Account Forfeiture Period, the following conditions exist:

9.5.1 Such Participant Account has a positive account balance and is claims-eligible;

9.5.2 No contributions to or withdrawals from the Participant Account have

occurred; and

9.5.3 No communications or other expressions of interest have been received by the Third-party Administrator from or on behalf of the Participant of such Participant Account.

For purposes of this Section 9.5, the "Unclaimed Account Forfeiture Period" shall be a continuous period that is equal to thirty (30) days less than the shorter of (i) the statutory period for forfeiture under the applicable State unclaimed property statute for such Participant Account or (ii) three years.

9.6 Limitation on Rights. Neither the establishment of this Plan, nor any modification or amendment thereof, nor the payment of any Benefits, nor the issuance of any insurance contracts shall be construed as giving any Participant, or any person whomsoever, any legal or equitable right against the Trustees, the State of Washington, its agencies, officers, employees, and institutions of higher education, or the Employers or Administrator or Third-party Administrator or any of their agents or employees, nor any right to the assets of the Plan, except as expressly provided herein.

9.7 Assignment. The interest of any Participant or Employer in any assets held on his or its behalf by the Trustee shall not be subject to assignment or alienation, either by voluntary or involuntary act of the Participant or Employer or by operation of law, and shall not be subject to assignment, attachment, execution, garnishment, or any other legal or equitable process, except to the extent required by law.

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

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IN WITNESS WHEREOF, Doug Detling, Chairman of the Board of Trustees, being duly authorized, on this 13th day of December, 2013 signed this Plan Document.

By: _____
Doug Detling, Chairman