VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION FOR PUBLIC EMPLOYEES IN THE NORTHWEST

LIMITED
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

Amended and Restated as of January 1, 2020

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 ("Limited HRA Plan" or "Plan"). The Trust may offer one or more HRA plans or forms of HRA plan coverage from time to time. The term "Plan" or "HRA Plan" shall refer to this Limited HRA Plan either individually or collectively with other plans or forms of plan coverage offered by the Trust as the context indicates or requires. This Plan is offered by a voluntary employees' beneficiary association under Internal Revenue Code §501(c)(9). The effective date for the Plan is October 1, 1990.

1.2 Plan Documents. This Plan document sets for the terms and conditions for certain types of limited coverage under the Limited HRA Plan. This Plan document, together with the Trust Agreement, the most current version of the Plan Summary, the Employer Adoption Agreement, as any of the above documents may be amended, restated, or replaced from time to time, and the completed individual Participant Enrollment File, shall constitute the Plan documents for Limited HRA Plan coverage. This Plan document amends, restates, and replaces the prior Standard HRA Pre-Medicare Limited-Scope Plan and the Post-separation HRA Pre-Medicare Limited Scope Plan documents in their entirety.

1.3 Limited HRA Coverage/Excepted Benefits Plan. Participants and their Dependents covered under this Limited HRA Plan may be subject to or may elect or may un-elect the specific Limited HRA Coverages offered under this Limited HRA Plan in accordance with the terms and conditions of this Plan, the Integrated HRA Plan, and the Post-separation HRA Plan; policies and procedures of the Administrator; and applicable law. The Plan may add additional types of Limited HRA Plan coverages or remove Limited HRA Plan coverages as permitted or required by applicable law or as determined by the Trustees in accordance with applicable law and the terms of the Plan Documents. Claims and recordkeeping administration for this Limited HRA Plan and other Plan coverages are administered under a contract separate from claims administration for the group health plan or other benefit plans of the Employer. During any period in which the Participant or any of his or her Dependents is automatically subject to or has elected coverage under this Limited HRA Plan, the Participant or the Dependent shall have the right to decline or revoke coverage under the Limited HRA Plan by notifying the Administrator by phone or in writing.

1.3.1 Limited-Scope/Excepted Benefits Coverage; Premium Tax Credit Eligibility. This Limited HRA Plan coverage is designed to be exempt from the Mandates as an HRA plan that provides only benefits that are considered Excepted Benefits as provided in 26 C.F.R. § 54.9831-1 (c)(3)(i)-(iv), and further described under Section 5.1. This Limited HRA Plan coverage (i) does not qualify as "minimum essential coverage," as defined under IRC §5000A, (ii) will not prevent a Participant from eligibility for an IRC §36B premium tax credit, (iii) will

not be reported on IRS Form 1095B as required by IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. § 54.9831-1(c)(3)(viii)..

1.3.2 Coverage for Coordination of Benefits and Section 111 Reporting. This Limited HRA Plan coverage is designed to be exempt from the Mandates as an HRA plan that provides only benefits are considered Excepted Benefits as provided in 26 C.F.R. § 54.9831-1(c)(3)(i)-(iii), and further described under IRS Notice 2015-87 Q&A-5 and Section 5.1. Excepted Benefits under this Limited HRA Plan coverage are further limited to only expenses and premiums for dental and vision in order to coordinate benefits for purposes of HRA coverage reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). This Limited HRA Plan coverage (i) does not qualify as "minimum essential coverage," as defined under IRC §5000A, (ii) will not prevent a Participant from eligibility for an IRC §36B premium tax credit, (iii) will not be reported on IRS Form 1095B as required by IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. § 54.9831-1(c)(3)(viii).

1.3.3 HSA Eligibility Coverage. Benefits under this Limited HRA Plan coverage may be expanded beyond Excepted Benefits only under certain circumstances set forth under Section 5.1 to allow a Participant to become eligible for contributions to a health savings account or HSA. Coverage for HSA eligibility purposes under this Limited HRA Plan (i) constitutes "minimum essential coverage," as defined under IRC §5000A, subject to the Mandates (ii) may preclude a Participant from eligibility for an IRC §36B premium tax credit (iii) will be reported on IRS Form 1095B as required by IRC §6055 for minimum essential coverage, and (iv) is not an "Excepted Benefit HRA" as defined in 26 C.F.R. § 54.9831-1(c)(3)(viii).

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

1.5 Definitions.

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

"Beneficiary" means a deceased Participant's beneficiary who inherits the right to receive Benefits payable from the remaining balance of a Participant Account after the Participant is deceased without any surviving Dependents. A Beneficiary can inherit the right to receive Benefits either as a former Dependent, an adult child of the Participant, a beneficiary designated by the Participant, or by operation of the terms of the Plan. A Beneficiary by operation of plan terms may arise in the absence of a valid beneficiary designation, if all of the designated beneficiaries predeceased, or if the Plan is unable to locate designated beneficiaries, all in accordance with the terms and conditions of Section 5.5 and policies and procedures of the Administrator.

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

"Card" means the debit/credit card(s) provided by the Administrator and used by Participants for the payment of Benefits under the Plan.

"Card Program" means the procedure and system established by the Administrator utilizing Cards for the payment of Benefits.

"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 Expenses under this Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations promulgated thereunder, as amended from time to time.

"Credited" means, with respect to the timing of a contribution made to a Participant Account, the date on which the Participant who received such contribution earned or became entitled to such contribution pursuant to the terms of this Plan, applicable collective bargaining agreements, Employer policies, or other Employer actions or adoption procedures.

"Dependent" means a Participant's spouse, dependent (as defined in IRC Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), or child (who as of the end of the taxable year has not attained age 27) as determined under IRC § 105(b).

"Employee" means any individual that an Employer determines is a current or former employee of such Employer, as the term "employee" is 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 the States of Washington, Oregon, and Idaho, or any political subdivision thereof; any local government, including any county, city, town, special purpose district within Washington, Oregon, or Idaho; or any agency or instrumentality of any of the foregoing or other entity that is sufficiently affiliated with the Employers for purposes of IRC §501(c)(9).

"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.

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

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

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

"Group Health Plan" or "GHP" means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) and such term "group health plan" is defined under IRC §§9832(a) and 5000(b)(1) and Treasury Regulation 54.9831-1(a)(1).

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

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

"Participant" means an Employee who has become eligible as a Participant as described in Article II. Except as specifically provided otherwise in this Plan document with respect to a Beneficiary, the term "Participant" as used in this Plan document and in the forms and literature used for administration of this Plan shall include any surviving spouse to whom a remaining balance in a Participant Account is transferred or any other person who becomes a Beneficiary under Section 5.5.

"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 and established for the purpose of the payment of Benefits.

"Participant Effective Date" for any Participant means, as applicable, any of the following: (i) the date specified by the Employer in the Participant Enrollment File or (ii) if no date is specified for a Participant on the Participant Enrollment File, the date on which both a contribution and the required enrollment information for such Participant have been received by the Plan 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 File" means the paper enrollment form, online enrollment information, or enrollment file provided by the Employer or a Participant with the information required by the Plan Administrator in order to enroll a Participant in the Plan.

"Plan Summary" means a written document that (1) summarizes the terms and conditions of the Plan, (2) informs participants, dependents, and other beneficiaries of Plan of their rights, benefits, and responsibilities under and with respect to the Plan, and (3) includes other information that is determined by the Administrator to be important, informational, or required by applicable law.

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

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

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

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

"Trustees" refers, collectively, to the individuals serving in their capacity as the Board of 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 is eligible to become a Participant (and the Dependents of such Participant become eligible for coverage) under this Limited HRA Plan on any date on or after the Participant Effective Date, that either (i) the Participant has for himself or herself or on behalf of his or her Dependents elected coverage under this Limited HRA Plan or (ii) the Participant or a Dependent fails to meet the requirements for coverage and eligibility for Benefits under the Standard HRA Plan or the Post-separation HRA Plan.

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

2.3 Duration of Participation. Once a Participant becomes Claims-Eligible under the Plan, the Participant's active status with respect to any Participant Account shall exist for so long as there is a positive account balance in such Participant Account, and thereafter, for such period as determined under the policies and procedures of the Administrator ("Account Closure Period"), but not to exceed two (2) years. If a Participant Account remains exhausted for the Account Closure Period, the Participant's active status with respect to such Account shall terminate after such Account Closure Period in accordance with the Plan's policies and procedures. A Participant who has lost his or her active status with respect to any Participant Account may subsequently become a Participant in the Plan

and Claims-Eligible as prescribed in Section 2.1. During any Account Closure Period for any Participant Account, a Participant may or may not receive statements or other plan communications with respect to such Participant Account, but will remain Claims-Eligible.

Article III.
Funding of Accounts

3.1 Contributions and Allocation of Assets. Each Employer shall contribute or transfer assets to this Plan, or designate assets to be subject to the terms of this Plan, on behalf of its eligible Employees pursuant to collective bargaining agreements, other written agreements, Employer benefits policies, and/or the terms of the Post-separation HRA, Standard HRA, or this Limited HRA Plan, as applicable. Employer contributions, transfers, or assets designated to be subject to the terms and conditions of this HRA Plan shall be specifically allocated to 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 portion of 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 Administrator 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 Administrator 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 complete Participant Enrollment File is not submitted for any amount allocated to a Participant Account, the Administrator will allocate such amount to one or more default investment options as determined by the Trustees until such time as further instructions are received from the Employer. Notwithstanding the foregoing, Plan contributions received as assets transferred from a prior qualified plan on behalf of an Employee for whom an Participant Enrollment File 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 Administrator or Third-party Administrator.

4.3 Accounting Steps. The Third-party Administrator shall adopt procedures and accounting steps to reflect changes in Plan assets and Participant Account balances, at such times and in such order as reasonably determined by the Administrator:

4.3.1 Allocate and credit any Employer contribution or transfer to this Plan 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

4.3.2 Adjust each Participant Account and Employer Account upward or downward, by an amount equal to the net income or loss accrued on balances within the Account; and

4.3.3 Asses, charge to, or deduct from 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, as the case may be, that have not been charged previously.

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

4.5 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 Administrator.

4.6 Notify the Plan of Errors within Ninety (90) Days. Participants and Employers should regularly review account information and immediately report any potential errors to the Administrator. Participants and Employers must notify the Administrator of an account error within ninety (90) days from the date the potential account error (a) is viewed by the applicable Participant or Employer online through the Plan portal or (b) appears on an account statement or other report received by the applicable Participant or Employer, whichever occurs first ("Notification Period"). Notification of any potential errors should be in writing in accordance with Section 4.6.1 below.

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

4.6.2 Investigation of Error. The Administrator will perform a timely investigation of any error notifications. The affected Participant(s) and/or Employer(s) will be notified regarding the results of the Plan's investigation and any corrective actions taken in accordance with the policies and procedures of the Administrator or as otherwise directed by the Trustees.

4.6.3 Corrective Action. Correction of any errors will be applied prospectively and, retroactively for any losses incurred during the Notification Period, including any investment losses, if such losses are the direct result of the negligent error or omission on the part of the Plan or its representatives. Where such errors are timely reported during the Notification Period, but the error is not corrected by the Administrator until after the close of the Notification Period, losses incurred after the close of the Notification Period will also be restored through the date of correction by the Administrator. However, in the event a Participant or Employer reports an error after the close of the Notification Period, neither the Plan, nor any of its representatives shall be liable for any losses incurred by a Participant or Employer, as applicable, arising after expiration of the Notification Period.

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

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

5.1 Benefits for Qualified Health Care Expenses. Benefits under this Limited HRA Plan must be a reimbursement for medical care expenses as defined by IRC §213(d) and IRC §106(f) and excludable from income under IRC §§105 and 106, as amended from time to time, subject to the limitations, terms, and conditions below and any other limitations, terms, and conditions, under this Plan document, applicable law, or as otherwise provided in policies and procedures of the Administrator. Benefits are payable for expenses incurred by the Participant or the Participant's Dependent(s), subject to the limitations under this Section, Section 1.3, Section 5.5. Benefits shall include Excepted Benefits expenses and premiums for qualified insurance coverage, reimbursed directly to the Participant.

5.1.1 General Limitations.

5.1.1.1 Reimbursements are limited to medical care expenses not covered by Social Security, Medicare, or any other health insurance contract or plan. Benefits may not include reimbursement for expenses that are deducted by the Participant under any section of the Internal Revenue Code, or for expenses which were incurred prior to becoming a Participant of the Plan.

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

5.1.1.3 Reimbursement for any claim submitted in accordance with this Article and the Plan may not exceed the current account balance in the applicable Participant Account at the time of reimbursement.

5.1.2 Specific Limited HRA Coverage Limitations. Participants covered under this Limited HRA Plan may be subject to or may elect or may un-elect any of the specific Limited HRA Plan coverages offered under this Limited HRA Plan in accordance with the terms and conditions of the Plan, policies and procedures of the Administrator, and applicable law. The Plan may add additional types of Limited HRA coverage or remove one or more types of Limited HRA Plan coverage as permitted or required by applicable law or as determined by the Trustees in accordance with applicable law and the terms of the Plan Documents. During any period in which the Participant or any of his or her Dependents is automatically subject to or has elected coverage under this Limited HRA Plan, the Participant shall have the right to

decline or revoke coverage under the Limited HRA Plan by notifying the Administrator by phone or in writing.

5.1.2.1 Limited-Scope/Excepted Benefits Coverage. Coverage for Participants and their Dependents under this Plan is based upon either (i) ineligibility for coverage under the Standard HRA Plan or Post-separation HRA Plan or (ii) an Employer's Plan design or election to provide Limited HRA Coverage for current employees who have an account under the Post-separation HRA Plan or (iii) an election of Limited HRA Coverage for those Participants eligible for coverage under the Standard HRA Plan or Post-separation HRA Plan in order for the Participant or a Dependent to become eligible for the premium tax credit under IRC §36B.

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

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

5.1.2 Claims for Benefits. Participants may file claims for Benefits on or after the date they become a Participant, provided the Third-party Administrator has received a complete Participant Enrollment File, 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).

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

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

5.3 COBRA. Participants or Dependents have a right to continue to make contributions and/or receive Benefits under this Plan for a specified time period if such rights are lost due to certain qualifying events, as prescribed by COBRA. COBRA continuation coverage for certain qualifying events is dependent on the Plan receiving notification of qualifying events within certain time periods as prescribed by COBRA. The Plan will administer continuation of COBRA using policies and procedures required or permitted by COBRA.

5.4 Health Care Debit Cards. Participants in the HRA Plan may, subject to a procedure established by the Administrator, use the Card(s) provided by the Administrator for payment of Benefits, subject to the provisions below.

5.4.1 Each Participant, by participating in the Card Program and using the Card(s), certifies that such Card shall only be used for Benefits and that any Benefit paid with the Card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

5.4.2 The Card shall be issued upon the Participant becoming Claims-Eligible, and is valid until reissued or replaced and for so long as the Participant remains a Participant in the Plan. The dollar amount of coverage available on the Card shall be subject to policies and procedures of the Administrator. Participant shall not use the Card to pay claims in excess of the dollar amount available on the Card.

5.4.3 The Cards shall only be used for permitted Benefits.

5.4.4 Participant shall be subject to the terms and conditions of the cardholder agreement, which shall be distributed with the Card.

5.4.5 Purchases made with the Cards shall be subject to the substantiation requirements of the Administrator. The Administrator, in its sole discretion, shall adopt procedures to ensure that amounts paid with the Card qualify as eligible Benefits under the Plan. Substantiation may be accomplished in accordance with policies and procedures of the Administrator, including without limitation, by Participant's submission of a receipt from a merchant or service provider describing the service or product, the date of the purchase, and the amount. Some charges shall be considered substantiated at or after the time of the Card charge by the nature of the charge and information collected at the time of the charge. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously substantiated as to amount, provider, and time period. At the point of sale, the service provider or merchant can provide or make available to the Administrator information to substantiate the charge. All charges not automatically substantiated shall be conditional, pending confirmation and substantiation of additional documentation or information.

5.4.6 Participants shall maintain records to substantiate payments of Benefits made with Cards. If the Card is used to pay an expense that is not automatically substantiated or otherwise independently verified without additional documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Administrator to verify that the amount was an eligible Benefit. If the Participant fails to provide information to satisfy the Administrator that amounts paid by use of the Card are eligible Benefits, the Administrator may, in its discretion, make the Plan whole by taking whatever action it deems appropriate to require the Participant to repay the amount that has not been verified, including:

(a) requesting the Participant to reimburse the Plan for the amount that has not been verified;

(b) offsetting future reimbursement of claims by the amount paid by use of the Card that has not been verified;

(c) suspending the activation on the Participant's Card; and

(d) suspending the Participant's eligibility to use the Card and participate in the Plan.

If the Administrator's correction efforts prove unsuccessful, the Participant remains indebted to the Plan for the amount of the payment that has not been verified. In that event, and consistent with its business practices, the Plan may treat the amount that has not been verified as it would any other business indebtedness. If the payment is not recovered within the timeframes specified in the policies and procedures of the Administrator, then the Plan may forgive the indebtedness, in which case the payment shall be reported as taxable income for the year in which the indebtedness is forgiven.

5.4.7 The Administrator, in its sole discretion, may adopt such other rules that it deems appropriate to govern the use of the Card to pay eligible Benefits (*e.g.*, establishing transaction limits on the Card, charging fees to use such Cards, etc.).

5.4.8 The Card is subject to cancellation upon the following: Participant's death; Participant's termination of his or her participation in the HRA Plan; Employer's termination of participation in the Plan; Participant's failure to produce proper forms and supporting documentation required for substantiation of the expense paid with the Card; or if Participant breaches any of his or her obligations under the cardholder agreement.

5.5 <u>Benefits Available in the Event of Death</u>.

5.5.1 <u>Participant and Dependent Benefits.</u> If a Participant dies with a vested, positive account balance in any Participant Account (including the circumstance where vesting occurs as a result of the death of the Participant in accordance with any applicable collective bargaining agreement, Employer policy, or other statement or action of the Employer), the remaining balance shall be applied as follows:

5.5.1.1 <u>Surviving Spouse</u>. The remaining balance may be transferred to the deceased Participant's surviving spouse, if any, who may file claims for Benefits incurred by the Participant and any Dependents, including the surviving spouse, until such account balance is exhausted. Benefits payable to a surviving spouse shall not include Benefits for any person(s) other than the surviving spouse and Dependents (if any) of the deceased Participant.

5.5.1.2 <u>No Surviving Spouse</u>. If the Participant dies without a surviving spouse but with other surviving Dependents or non-Dependent children, or if the surviving spouse of the deceased Participant subsequently dies with other surviving Dependent(s) or non-Dependent children of the Participant, the executor, administrator, or other representative of the Participant's estate may file claims for any remaining eligible expenses incurred by the Participant or the surviving spouse, as applicable. After the payment of all remaining eligible expenses of the Participant or surviving spouse, as applicable, the Plan may, subject to the policies and procedures of the Administrator, divide and transfer the remaining balance in a vested Participant Account in equal amounts to individual accounts assigned to each of the Participant's surviving Dependents and non-Dependent children. In such event, the guardian(s) of any surviving Dependent(s) may file claims for eligible Benefits of the Dependent(s) and the non-Dependent children may file claims for eligible benefits until such account

balance is exhausted. Furthermore, the Participant may elect, in accordance with the policies and procedures of the Administrator, to bypass any non-Dependent children in favor of a Designated Beneficiary(ies).

5.5.1.3 Treatment of Stepchildren. At the Participant's election, as the same may be made in accordance with the policies and procedures of the Administrator, a step child or the stepchildren of the Participant may be either included the same as any biological or adopted children, or bypassed in the survivor benefits in the same manner as any non-Dependent children. In the event of no Participant election, any Dependent stepchildren will be included in the survivor benefits the same as biological or adopted children, and any non-Dependent stepchildren will be excluded from survivor benefits.

5.5.1.4 Spouse and Dependent Right to Disclaim; Other Coverage Limitations. Any spouse, Dependent, or non-Dependent child of the Participant to whom all or a portion of the Participant Account balance is transferred pursuant to this Section 5.5.1 shall:

(a) have the right to disclaim his or her right to continued Benefits under the Plan as permitted by applicable state law, including without limitation, the Washington state statutory provisions of RCW 11.86.021, as amended, concerning disclaimer of interests and in accordance with the policies and procedures of the Administrator; and

(b) no longer be eligible for coverage under the Standard HRA Plan but shall be covered by this Post-separation HRA Plan and subject to the terms and conditions of the Post-separation HRA Plan document.

5.5.2 Beneficiary Benefits. This Plan (a) is part of a medical trust that is established on behalf of State and political subdivisions of Washington, Oregon, and Idaho, (b) has received a favorable ruling from the Internal Revenue Service that the trust's income is not includible in gross income by reason of the exemption from income tax provided to the Trust under IRC §501(c)(9), (c) on or before January 1, 2008, provided for reimbursements of Qualified Health Care Expenses of a deceased employee's heirs and beneficiaries, and (d) qualifies to provide Benefits to a deceased employee's beneficiaries under IRC §105(j).

5.5.2.1 General Beneficiary Terms. At any time after the death of a Participant and the Participant's spouse (if any), any vested funds then remaining in the applicable Participant Account may be transferred to one or more Beneficiaries as provided in this Section 5.5.2. A person's right to be a Beneficiary, and a Beneficiary's eligibility for Benefits from the remaining vested balance of a Participant Account, are subject to the rights and restrictions of applicable law, the terms and conditions set forth in this Section 5.5, and the policies and procedures of the Administrator, as the same may be amended from time to time. Benefits payable to Beneficiaries shall not include Benefits for the Dependents of the Beneficiary (either before or after the death of the Beneficiary). Beneficiaries determined under this Section 5.5.2 shall not be eligible for coverage under the Standard HRA Plan but shall be covered by the Post-separation HRA Plan or this Limited HRA Plan, in accordance with the terms and conditions of the Post-separation HRA Plan document or this Limited HRA Plan document, as applicable.

5.5.2.2 Benefits Remain Available for Surviving Dependents and Non-Dependent Children. To the extent all or a portion of the Participant Account of a deceased Participant has been previously transferred to or allocated among one or more qualified Dependents and non-Dependent children of the Participant:

(a) Each non-Dependent child to whom a portion of the Participant Account was transferred or allocated shall be a Beneficiary, and

(b) Each surviving Dependent to whom a portion of the Participant Account was transferred or allocated shall become a Beneficiary as of the earlier of (1) January 1 of the year after such Dependent turns the age of 26 or (2) the date on which such Dependent otherwise loses status as a qualified Dependent.

5.5.2.3 Benefits Available for Designated Beneficiaries. A Participant may designate one or more persons who may be eligible as a Beneficiary for Benefits payable from the balance remaining in the applicable Participant Account in the event: (1) there are no eligible surviving Dependents or non-Dependent children of the Participant as provided under Section 5.5.1.2; (2) the Participant has no surviving Dependents and has elected to bypass non-Dependent children and/or stepchildren in favor of a Designated Beneficiary(ies); or (3) as otherwise permitted by the Administrator and applicable law. In order to be effective to transfer an interest in the Benefits payable from the remaining balance of a Participant Account, a Participant's beneficiary designation must be properly made and delivered to the Plan, according to policies and procedures of the Administrator, prior to the Participant's death. A Beneficiary designated under this Section 5.5.2.3 shall be eligible as a Beneficiary only if the Participant and the Participant's spouse decease with no surviving Dependents or non-Dependent children of the Participant as provided under Section 5.5.1.2 (except in cases where the Participant elects to bypass any non-Dependent children and/or stepchildren) or as otherwise permitted by the Administrator and applicable law. Beneficiaries under this Section 5.5.2.3 shall be allocated equal percentages in the remaining balance of the Participant Account.

5.5.2.4 Benefits Available for Certain Heirs. In the absence of (1) any Beneficiary under Section 5.5.2.2, (2) a valid Beneficiary designation under Section 5.5.2.3, and (3) the ability of the Plan to locate any Beneficiaries designated by the Participant under Section 5.5.2.3, the remaining balance under a Participant Account of a Participant or surviving spouse who decease with no surviving Dependents or non-Dependent children of the Participant as provided under Section 5.5.1.2 may be transferred to one or more of the following persons in the order provided below, such that if there are one or more Beneficiaries at any level, persons in subsequent levels will not be eligible as Beneficiaries. To the extent there is more than one eligible Beneficiary at any level under this Section 5.5.2.4, Beneficiaries at that level shall be allocated equal percentages in the remaining balance of the Participant Account.

First level: To state registered non-dependent domestic partners.

Second level: To any grandchildren of the deceased Participant.

Third level: To any siblings of the deceased Participant who share the same two biological parents of the deceased Participant.

Fourth level: To any parents of the deceased Participant.

Fifth level: To any nieces and nephews of the deceased Participant.

Sixth level: To any aunts and uncles of the deceased Participant.

Seventh level: To any cousins of the deceased Participant.

5.5.2.5 Beneficiary's Right to Disclaim; Other Coverage Limitations. Any Beneficiary to whom all or a portion of the Participant Account balance is transferred pursuant to this Section 5.5.2:

(a) shall have the right to disclaim his or her right to continued Benefits under the Plan as permitted by applicable state law, including without limitation, the Washington state statutory provisions of RCW 11.86.021, as amended, concerning disclaimer of interests and in accordance with the policies and procedures of the Administrator; and

(b) shall not be eligible for coverage under the Standard HRA Plan but shall be covered by but shall be covered by the Post-separation HRA Plan or this Limited HRA Plan, in accordance with the terms and conditions of the Post-separation HRA Plan document or this Limited HRA Plan document, as applicable; and

(c) shall not, and his or her Dependents shall not, have rights under COBRA.

5.5.3. Tax Reporting and Withholding on Beneficiary Benefits. A Beneficiary's eligibility for Benefits, the valuation of Plan coverage, and the reporting, withholding and/or payment (if any) of taxes applicable to such coverage shall be subject to applicable law and the rules, policies, and procedures of the Administrator.

5.5.4 Plan Document Preempts Will or Trust. To the extent permitted by applicable state law, including without limitation, Washington state statutory provisions of RCW 11.02.091, as amended, the Plan provisions under this Section 5.5 shall take precedence over the terms of a will or trust or the intestate succession laws that would otherwise govern the transfer of a Participant's interest in a Participant Account and the Benefits payable thereunder.

5.5.5 Authority of Spouse and Reliance on Death Certificate. In accordance with the Administrator's rules, policies, and procedures, and subject to applicable law, the Plan may rely upon a copy of the official death certificate of the Participant for proof of the Participant's marital status and identification of the Participant's spouse and any other information represented on the death certificate. Should the Participant have a surviving spouse identified on the death certificate, the surviving spouse shall have the authority to file claims, handle the Participant Account, and provide further information to the Plan without further court documentation or proof of the spouse's authority in handling the Participant's estate. For purposes of handling the deceased Participant's Account, evidence of a surviving spouse represented on the Participant's death certificate shall take precedence over the terms of a will, trust, or other court documentation naming another individual as the authoritative party handling the Participant's estate.

5.5.6 Re-allocation After the Death of Another Dependent or Beneficiary. If, after the death of a Participant and the Participant's spouse, any Dependent or Beneficiary to whom a portion of the Participant Account was transferred or allocated dies, any remaining balance in the Account previously transferred or allocated to such Beneficiary shall be transferred or allocated in equal shares to any other surviving Dependents or Beneficiaries with a remaining positive Account balance.

5.5.7 Forfeiture of Remaining Balance. After the death of a Participant with no surviving Dependents or Beneficiaries, or if no surviving Dependents or potential Beneficiaries can be located by the Plan, any vested funds then remaining in the applicable Participant Account shall be forfeited and applied as provided in Section 5.6. Any vested balance that remains in an account previously transferred or allocated to a Beneficiary after the death of the Beneficiary with no other surviving Dependents or Beneficiaries as provided in Section 5.5.6, shall be forfeited and applied as provided in Section 5.6.

5.5.8 Procedure for Locating Beneficiaries. For any potential Beneficiary under this Section 5.5, the Plan may rely on (1) a certification of a personal estate representative or other legal representative of the Participant's estate acceptable under the policies or procedures of the Administrator, or (2) in the absence of a personal estate representative or other legal representative, certifications of potential Beneficiaries as to whether another potential Beneficiary remains alive and to provide any other information that may assist the Plan in locating the potential Beneficiary. If the whereabouts of a potential Beneficiary remain unknown, the Plan shall hold the transfer of the account open for at least 180 days from the date the Administrator determines the Beneficiary's whereabouts to be unknown, to allow the Beneficiary to claim his or her interest in the account. During such 180-day period, the Plan may (but shall not be obligated to) use reasonable means to locate the potential Beneficiary. If the Administrator determines after such 180-day period that there are no eligible Beneficiaries to whom the remaining balance in a Participant Account may be transferred pursuant to the terms of this Section 5.5, the Administrator may forfeit the remaining Account balance as provided in Section 5.5.7.

5.5.9 Plan Interpretation after the Death of a Participant. For purposes of interpretation of Plan terms and administration of this Plan, except as specifically provided otherwise in this Plan document, once remaining funds in a Participant Account are transferred or allocated to a Beneficiary under Section 5.5, references in this Plan document, the Post-separation HRA Plan document, the Limited HRA Plan document, and in the forms and literature used for administration of each of those Plans to the term "Participant" shall include any Beneficiary of the Participant.

5.6 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 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, in all cases to the fullest extent permitted by applicable law and subject to the rules, policies and procedures established by the Administrator.

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 Plan, the Trust, Trustees, or Administrator, nor any of their agents, subcontractors, representatives, officers, or employees shall be responsible for confirming or enforcing the terms of collective bargaining agreements, Employer policies, or other agreements regarding the terms of an Employee's eligibility to participate or amounts to be contributed on behalf of a Participant under this 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 Administrator 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 default investment options as determined by the Trustees. Separate investments shall not be required to be maintained with respect to separate Participant Accounts or Employer Accounts. Any potential errors discovered regarding the investments of a Participant Account or Employer Account must be reported to the Plan in accordance with Section 4.6.

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 Benefits to the Third-party Administrator for the Trust.

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 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 Health Care Debit Card Transactions are Not Claims. The presentation or use of a Card for payment at a merchant or vendor is not considered a submission of a claim under the Plan. In the event the merchant or vendor denies the transaction or the transaction is unable to be processed at the point of sale with that merchant or vendor, such denial of the transaction at the point of sale shall not be considered a denial under the Plan. If the transaction is approved at the point-of-sale, but the transaction is not electronically validated at the point of sale or later independently substantiated without further documentation, the Participant must submit such itemized bills, receipts, or other information requested by the Third-party Administrator to verify that the amount was an eligible expense reimbursable by the Plan. Where the Third-party Administrator determines that an expense is not eligible to be paid with the Card because the Participant or Dependent has not submitted the information requested by the Third-party Administrator to substantiate the claim as an expense reimbursable under the Plan (*e.g.*, where the Card is suspended, the Plan requests reimbursement of the unsubstantiated expense and/or the Plan applies an overpayment against the applicable Participant Account and offsets against future claims), then denial of such Card payment would become a denial subject to the claims and appeals procedures under this Section 6.

6.7 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).

6.7.1 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:

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

6.7.1.2 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;

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

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

6.7.1.5 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;

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

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

6.8 Employer Uses of Protected Health Information.

6.8.1 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 6.8 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.

6.8.2 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.

6.8.3 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.

6.8.3.1 *"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 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

6.8.4 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 6.8.5 and obtaining written certification pursuant to Section 6.8.8, 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.

6.8.4.1 *"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.

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

6.8.4.3 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).

6.8.5 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 6.8.8 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:

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

6.8.5.2 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;

6.8.5.3 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;

6.8.5.4 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;

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

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

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

6.8.5.8 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;

6.8.5.9 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

6.8.5.10 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.

6.8.6 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 6.8.8 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.

6.8.7 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 6.8.8 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.

6.8.7.1 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.

6.8.8 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 6.8.5 and all other conditions and requirements of this HIPAA Plan Amendment.

6.9 Qualified Medical Child Support Orders and National Medical Support Notices. The Plan shall comply with all applicable rules and laws relating to Qualified Medical Child Support Orders ("QMCSO") and National Medical Support Notices ("NMSN"). In the event a QMCSO or NMSN is received by the Plan, the Plan will follow the policies and procedures for determining and administering such order or notice as the same may be adopted or revised from time to time by the Administrator.

Article VII.
Administrator

7.1 Rights & Duties. The Trustees shall enforce this Plan in accordance with its terms and shall be charged with its general administration. In its capacity as the Administrator, the Board of 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 Administrator 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 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 Administrator 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 Administrator of such other information as may be pertinent to the 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 Administrator including the following: income statement, balance sheet, year to date budget, number of Participant Accounts, and other such reports which are permitted by law, or as the Administrator and/or Employers request and agreed to by the 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 Administrator from time to time. Additionally, all other necessary Plan expenses, including but not limited to: legal, benefits staff, Third-party Administrator, auditing, printing, postage, mail service, 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 Administrator from time to time.

7.4 Consultants, Investment Managers, Third-party Administrators, Lawyers & Accountants. Reasonable expenses to administer the Plan may be paid by assessments from the Participants' Accounts as determined by the Administrator from time to time, which may be made by adjustments to investment earnings/losses or by a deduction from account balances. Plan expenses can include but are not limited to: services for legal, benefits staff, third-party administrator, auditing, printing, postage, mail, plan administration software or technology, trustee, banking, plan or trust consulting, investment management, database search, and, to the extent permitted by applicable law, all governmental fees, taxes, and assessments.

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 Gallagher Benefit Services, Inc.
906 W 2nd Avenue, Suite 400
Spokane, WA 99201-4537
(509) 838-5571 Telephone
(509) 838-5613 Fax
Charlie_Isaacs@ajg.com

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

Article VIII.
Amendment & Termination

8.1 Permanency. It is the expectation of the 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 File are all parts of a single, integrated employee benefit plan and shall be construed together. In the event of any conflict between the terms of this Plan and the Participant Enrollment File, the Employer Adoption Agreement and the terms of the Trust, such conflict shall be resolved first by reference to the Trust Agreement, then the Plan Document, then the Employer Adoption Agreement, and then the Participant Enrollment File.

9.2 Applicable Law; Severability. Except as may be required by §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. In an effort to preserve Participant Accounts from becoming unclaimed or forfeited, the Administrator may implement policies and procedures and engage third-party services to locate Participants. Notwithstanding the above, the account balance in a Participant Account shall be forfeited and applied as provided in Section 5.6 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 or, in accordance with the policies and procedures of the Plan, the Plan Administrator has determined that the Participant is not locatable; 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, Douglas Detling, Chairman of the Board of Trustees, being duly authorized, on this 1 day of January, 2020 signed this Plan Document.

By: _____
Douglas Detling, Chairman