THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

Amended and Restated Effective January 1, 2021

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THE COUNTY OF RIVERSIDE FLEXIBLE BENEFIT PROGRAM

ARTICLE I
INTRODUCTION

1.1 Creation and Title.

The County of Riverside, a political subdivision of the State of California (the "County"), previously established and has maintained The County of Riverside Flexible Benefit Program (the "Plan"). The County hereby amends the Plan under the terms and conditions set forth in this document. The Plan incorporates The County of Riverside Health Care Reimbursement Plan (the "Health Care Reimbursement Plan") (attached as Schedule A) and The County of Riverside Dependent Care Reimbursement Plan (the "Dependent Care Reimbursement Plan") (attached as Schedule B).

1.2 Effective Date.

The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2021. The Plan was originally effective November 20, 1986.

1.3 Purpose.

The purpose of the Plan is to allow Eligible Employees to select among Compensation and coverage under one or more Benefits maintained by the County. The County intends that the Plan qualify as a cafeteria plan under Code Section 125 and that the Benefits provided under the Plan be eligible for exclusion from federal income tax. The Plan is intended to qualify as a "Cafeteria Plan" within the meaning of Code Section 125, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Section 125.

The provisions of The County of Riverside Health Care Reimbursement Plan are intended to qualify as a self-insured medical expense reimbursement program that provides benefits described by Code Sections 105 and 106, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Sections 105 and 106. The health care reimbursement benefits reimbursed under such Health Care Reimbursement Plan are intended to be eligible for exclusion from participating Employees' income under Code Section 105(b).

The provisions of The County of Riverside Dependent Care Reimbursement Plan are intended to qualify as a "dependent care assistance program" under the provisions of Code Section 129, and it shall be construed and interpreted, to the greatest extent possible, in a manner consistent with the requirements of Code Section 129. The dependent care reimbursement benefits reimbursed under such Dependent Care Reimbursement Plan are intended to be eligible for exclusion from participating Employees' income under Code Section 129(a).

The provisions of the Plan, as reflected in this document, are applicable only to Eligible Employees who are in the active employ of the County on or after January 1, 2021.

1.4 Compliance with the Code and Other Applicable Laws.

It is intended that the Plan meet all applicable requirements of the Code and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

The Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan components of the Plan are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Health Care Reimbursement Plan component of the Plan is subject to HIPAA and COBRA; whereas, the Dependent Care Reimbursement Plan is not. The Plan shall be designated as a hybrid entity for purposes of HIPAA, and the Cafeteria Plan shall be a covered entity only with respect to the Health Care Reimbursement Plan.

In addition, the Plan will comply with the requirements of all other applicable law.

ARTICLE II
DEFINITIONS

As used in this Plan document, the following terms shall have the following meanings:

2.1 "Benefit" means one of the various qualified benefits under Code Section 125(f) sponsored by the County and made available by the County through the Plan, including but not limited to medical plans (including prescription drug components), dental plans, vision plans, and health care and dependent care reimbursement benefits.

2.2 "Benefits Account" means one of the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

2.3 "Benefits Enrollment Application" means the completion of paper forms and/or submission of electronic enrollment, including a Salary Reduction Agreement, evidencing an Eligible Employee's elections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.

2.4 "Code" means the Internal Revenue Code of 1986, as amended from time to time, or superseded by laws of similar effect, and all applicable regulations and guidance thereunder.

2.5 "Compensation" means all the earned income, salary, wages and other earnings, except bonuses and overtime, paid by the County to a Participant during a Plan Year, including any amounts contributed by the County pursuant to a Salary Reduction Agreement which are not includable in gross income under Code Sections 125, 402(g)(3), 402(h), 403(b), or 457(b).

2.6 "County" means the County of Riverside, a political subdivision of the State of California, or any of its affiliates, successors, or assignors which adopt the Plan.

2.7 "Dependent" means an individual who is a dependent within the meaning of Code Section 152(a) and modified by Code Sections 105 and 106 by an Employee. Notwithstanding the previous sentence, with respect to dependent care reimbursement Benefits, "Dependent" shall have the meaning as set forth in the Dependent Care Reimbursement Plan.

2.8 "Eligible Employee" means an Employee, as defined below, who has met the eligibility requirements of the Plan set out in Section 3.1.

2.9 "Employee" means an individual employed by the County in a regular position, as defined in Salary Ordinance No. 440 of the County. The term Employee excludes "per diem, temporary, and seasonal employees," as defined in Salary Ordinance No. 440 of the County; "leased employees" as defined in Code Section 414(n); and each individual whom the County treats as an independent contractor, even if s/he might otherwise satisfy certain of the legal tests or criteria to be considered a common law employee of the County.

2.10 "Entry Date" means, for each Eligible Employee, the first day that the Employee becomes eligible to participate in the Plan.

2.11 "Participant" means any Eligible Employee who has elected to participate in the Plan by providing the Plan Administrator with an executed Salary Reduction Agreement and Benefits Enrollment Application.

2.12 "PHSA" means the Public Health Service Act of 1996, as amended from time to time, or superseded by laws of similar effect, and all applicable regulations and guidance thereunder.

2.13 "Plan" means The County of Riverside Flexible Benefit Program, as described herein, including the incorporated The County of Riverside Health Care Reimbursement Plan (attached as Schedule A) and The Country of Riverside Dependent Care Reimbursement Plan (attached as Schedule B).

2.14 "Plan Administrator" means the Human Resources Director of the County, or such other person or committee as may be appointed by the County to administer the Plan.

2.15 "Plan Year" means the 12-consecutive month period beginning on January 1 and ending on December 31.

2.16 "Salary Reduction Agreement" means the agreement by an Eligible Employee authorizing the County to reduce the Eligible Employee's Compensation on a pre-tax basis while a Participant during the Plan Year for purposes of making contributions toward Benefits under the Plan.

2.17 "Spending Credits" mean an amount made available to a Participant by the County in a Plan Year for use in purchasing Benefits available under the Plan.

2.18 "Spouse" means an individual who is legally married to an Employee but shall not include an individual separated from an Employee under a decree of legal separation.

2.19 "Status Change" means any of the following with respect to Benefits under the Plan. A change in election as a result of a Status Change must on account of and consistent with the Status Change, as permitted and pursuant to Code Section 125. The Plan Administrator shall have the authority to determine whether a requested change in election is on account of and consistent with a Status Change.

The following Status Changes apply to medical, dental, vision, health care reimbursement, and dependent care reimbursement benefits:

(a) **Legal marital status.** Events that change an Eligible Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
(b) **Number of Dependents.** Events that change an Eligible Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption.
(c) **Employment status.** Any of the following events that change the employment status of the Eligible Employee, Spouse, or a Dependent: a termination or commencement of

employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan or other employee benefit plan of the County or the employer of a Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the Plan, then that change constitutes a change in employment under this paragraph.

(d) **Dependent first satisfies or ceases to satisfy eligibility requirements.** Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(e) **Residence.** A change in the place of residence of the Eligible Employee, Spouse, or Dependent.

The following Status Changes apply only to medical, dental, vision, and health care reimbursement benefits:

(a) **Judgment, decree, or order.** This paragraph applies to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a "qualified medical child support order" as defined in Section 609 of the Employee Retirement Income Security Act of 1974, as amended) that requires accident or health coverage for the Eligible Employee's child or for a foster child who is a Dependent of the Eligible Employee (except that any child to whom Code Section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Eligible Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan or permit the Eligible Employee to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child.

(b) **Entitlement to Medicare or Medicaid.** If an Eligible Employee, Spouse, or Dependent who is enrolled in the Plan becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Plan shall permit the Eligible Employee to make a prospective election change to cancel or reduce coverage of that Eligible Employee, Spouse, or Dependent under the Plan. In addition, if an Eligible Employee, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Eligible Employee to make a prospective election to commence or increase coverage of that Eligible Employee, Spouse, or Dependent under the Plan.

The following Status Changes apply only to medical, dental, vision, and dependent care reimbursement benefits:

(a) **Cost changes.** The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "significant" change for purposes of this subsection.

   (1) **Automatic changes.** If the cost for a Benefit shall increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, make a corresponding change in the amount of salary reductions accruing for the remainder of the Plan Year.

(2) **Significant cost changes.** If the cost for a Benefit significantly changes during a Plan Year, an Eligible Employee may revoke his/her election and, in lieu thereof, make a corresponding change in election under the Plan. Changes that may be made include commencing participation in a Benefit with a decrease in cost, or, in the case of an increase in cost, revoking an election for that Benefit and, in lieu thereof, either receiving on a prospective basis coverage under another Benefit providing similar coverage or dropping coverage if no other Benefit providing similar coverage is available.

(3) **Application to Dependent Care Reimbursement Plan.** A Participant may elect to increase contributions to the Dependent Care Reimbursement Plan if there is a significant increase in the cost of dependent care that is not provided by a Relative of the Participant. The cost increase may result from the Participant electing to increase the compensation paid to the dependent care provider. For purposes of this provision, a "Relative" of the Participant is any individual who is related to the Participant in one of the ways described in Code Sections 152(a)(1) through (8), utilizing the rules in Code Sections 152(b)(1) and (2).

(b) **Coverage changes.**

(1) **Significant curtailment without loss of coverage.** If an Eligible Employee (or his/her Dependent) has a significant curtailment of coverage under a benefit plan during a Plan Year that is not a loss of coverage, the Eligible Employee may revoke his/her election for such significantly curtailed coverage and, in lieu thereof, elect to receive coverage on a prospective basis under another available benefit plan providing similar coverage.

(2) **Significant curtailment with loss of coverage.** If an Eligible Employee (or his/her Dependent) has a significant curtailment of coverage under a benefit plan during a Plan Year that is a loss of coverage, the Eligible Employee may revoke his/her election for such significantly curtailed coverage and, in lieu thereof, either elect to receive coverage on a prospective basis under another available benefit plan providing similar coverage or, if no such other benefit plan exists, to drop coverage entirely.

(3) **Addition/improvement of benefit.** If a new Benefit is added or if coverage under an existing Benefit is significantly improved during a Plan Year, an Eligible Employee may revoke his/her election under the Plan and, in lieu thereof, make an election for coverage under the new or improved Benefit.

(4) **Change in coverage under another employer plan.** An Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the County or another employer) if: (i) the other plan permits participants to make an election change that would be permitted under this Section 2.19, disregarding this provision; or (ii) the other plan permits participants to make an election for a plan year that is different than the Plan Year under the Plan.

(5) **Definition of significant curtailment.** Coverage under a benefit plan is significantly curtailed for purposes of this subsection only if there is an overall reduction in coverage provided under such benefit plan so as to constitute reduced coverage

generally (for example, a significant increase in the deductible, the copayment, or the out-of-pocket cost sharing). The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "significant" curtailment in coverage for purposes of this subsection.

(6) **Definition of loss of coverage.** A loss of coverage for purposes of this subsection means a complete loss of coverage under the elected benefit plan (including the elimination of a benefit plan or an HMO ceasing to be available in the area where the individual resides). A loss of coverage also means a substantial decrease in the medical care providers available under the benefit plan (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO). A loss of coverage shall include coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator shall, in its sole and absolute discretion, determine what constitutes a "loss of coverage" for purposes of this subsection.

The following Status Changes apply only to the medical benefit:

(a) **Enrollment in marketplace coverage.** A Participant may revoke his/her election for medical coverage (but not for coverage under the Health Care Reimbursement Plan) for him/herself and his/her Dependents in order to purchase a qualified health plan through a marketplace established under Section 1311 of the Patient Protection and Affordable Care Act of 2010; provided that the Participant certifies that s/he and his/her Dependents have enrolled or intend to enroll in a qualified health plan under the marketplace that is effective beginning no later than the day immediately following the last day of the Plan's medical coverage that is revoked.

(b) **Reduction in work hours**. A Participant may revoke his/her election for medical coverage (but not for coverage under the Health Care Reimbursement Plan) for him/herself and his/her Dependents due an employment status change; provided that: (i) the Participant had been in an employment status with the County under which s/he was reasonably expected to average at least 30 hours of service per week and there is a change in his/her employment status so that s/he is reasonably expected to average less than 30 hours of service per week, even though the reduction in hours does not result in him/her ceasing to be eligible for medical coverage under the Plan; and (ii) the Participant certifies that s/he and his/her Dependents have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the Plan's medical coverage is revoked.

ARTICLE III
PARTICIPATION

3.1 Eligibility.

Each Employee who is a member of a group of Employees which is:

(a) Represented for collective bargaining purposes by an association or union which adopts the Plan through a Memorandum of Understanding with the County; or
(b) Within a classification of Employees with respect to which the County adopts the Plan by Exempt Management, Management, Confidential, Unrepresented Resolution ("Management Resolution")

shall be eligible to participate in the Plan if the Employee is eligible to participate in the County's medical, dental, vision, health care reimbursement, and dependent care reimbursement benefits and so long as the Employee is employed by the County as of his/her Entry Date. If a Participant transfers to any position which is not covered by the Plan, s/he will cease to be a Participant. The individual will again be eligible to become a Participant when s/he returns to a position covered by the Plan.

3.2 Commencement of Participation.

An Eligible Employee shall become a Participant in the Plan after executing a Benefits Enrollment Application setting forth the Benefits to be made available to the Eligible Employee for the immediately following Plan Year or, with respect to an Eligible Employee's initial election period, the remaining portion of the Plan Year that contains the Eligible Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the County to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. An Eligible Employee must execute the Benefit Enrollment Application and a Salary Reduction Agreement within 60 days of the Entry Date.

3.3 Irrevocability of Elections.

A Participant (or an Eligible Employee with respect to an election not to participate in the Plan) may not modify his/her Benefits elections at any time during the Plan Year, except as provided for under Section 4.3.

3.4 Election Change Procedure for Forthcoming Plan Years.

If a Participant wants to change his/her elections for a forthcoming Plan Year (or an Eligible Employee want to enroll for the forthcoming Plan Year), the Participant or Eligible Employee must, before the end of the first Plan Year of participation and before the end of each subsequent Plan Year, provide the Plan Administrator with a newly executed Benefits Enrollment Application. Each new Benefits Enrollment Application shall specify the type and amount of Benefits to be made available to the Participant for the immediately following Plan Year. Should a Participant fail to execute a valid Benefit Enrollment Application for any Plan Year before the start of the Plan Year, the Benefits Enrollment Application for the immediately preceding Plan Year shall be deemed to be effective for the subsequent Plan Year. In addition, the Participant shall be deemed to have executed a valid Benefits Enrollment Application for purposes of determining the source

and amount of contributions to the Plan pursuant to Article IV of the Plan. A Participant may also elect not to participate for a particular Plan Year by submitting an "Election to Pay Premiums with After-Tax Dollars" form prior to the start of the Plan Year.

Notwithstanding the above, a Participant or Eligible Employee who fails to execute a valid Benefits Enrollment Application for any Plan Year before the start of the Plan Year with respect to participation in the Health Care Reimbursement Plan or Dependent Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

3.5 Changes in Elections by Plan Administrator

Notwithstanding any other provision of the Plan, the Plan Administrator may take such action, as appropriate in the discretion of the Plan Administrator, to rectify erroneous salary reduction contributions, contributions and credits to the extent permitted by applicable law.

3.6 Term of Participation.

Each Participant shall be a Participant in the Plan for the entire Plan Year or the portion of the Plan Year remaining after the Participant's Entry Date, if later than the first day of the Plan Year. A Participant shall cease to be a Participant in the Plan on the earliest of:

(a) The end of the month following the month in which the Participant ceases to be an Eligible Employee, resigns, or terminates employment with the County, subject to the provisions of Section 3.3;
(b) The date the Participant fails to make required contributions under the Plan;
(c) The date the Participant dies; or
(d) The date the Plan terminates.

3.7 Participation by Rehired Employees.

If a terminated Eligible Employee is rehired by the County in the same Plan Year and within 30 days following his/her termination of employment, such Eligible Employee shall resume participation in the Plan under the terms of the Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year. If a terminated Eligible Employee is rehired by the County either more than 30 days following his/her termination of employment or in a new Plan Year, such Eligible Employee shall be a new Eligible Employee and shall make new elections to participate in the Plan.

3.8 HIPAA Special Enrollment Rights.

Notwithstanding any other provisions in this Article III, any Employee who becomes eligible under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for coverage by an accident or health benefit under the Plan shall have special enrollment rights and shall be allowed to participate in the Plan, so long as such Employee complies with the provisions set out in HIPAA, as reflected in PHSA Section 2704(f).

3.9 COBRA Continuation Coverage.

Notwithstanding any other provisions in this Article III, any Participant, Spouse, or Dependent eligible for continuation coverage under Code Section 4980B shall be allowed to continue to participate in the health care Benefits, so long as such Participant, Spouse, or Dependent

complies with the provisions set out in PHSA Sections 2201–2208.

The County shall adopt rules relating to continuation coverage for health care Benefits, as provided under PHSA Sections 2201–2208 (or applicable state law), as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.10 Family Medical Leave Act.
Subject to any provision in the Code governing Family and Medical Leave Act ("FMLA") and California Family Rights Act ("CFRA") leave coverage to the contrary, FMLA/CFRA continuation coverage of health care Benefits shall be available to all qualifying Participants.

If the leave is paid, contributions may continue to be made under the Plan as elected under Section 3.2.

Payment options for coverage while on unpaid leave include:

(a) Pre-pay before commencement of the leave, through a pre-tax or an after-tax Salary Reduction Agreement, from any taxable Compensation, provided all other Plan requirements are met; or
(b) Participants may pay their share of contributions on the same schedule as payments would be made if the Participant were not on leave or under another schedule permitted under Department of Labor regulations and approved by the Plan Administrator.

If a Participant is away from work during an approved non-FMLA absence without pay, any of the above options may also be allowed.

The County shall not be required to continue the coverage of a Participant who fails to make required contributions while on FMLA, CFRA, or other leave. However, if the County chooses to continue the coverage of a Participant who fails to make required contributions while on leave, the County is entitled to recoup those payments after the Participant returns from leave.

3.11 Uniformed Services Employment and Reemployment Rights Act ("USERRA").
If a Participant takes a military leave of absence or the Participant terminates employment to enter into military service, the Participant may elect to continue coverage of the health care Benefits in accordance with the requirements of USERRA or other applicable law. The County shall notify the Participant in advance, in writing, of the terms and conditions of contributions during the military leave and shall comply with USERRA for both continuation of health care Benefits and reinstatement rights.

ARTICLE IV
CONTRIBUTIONS

4.1 Source of Contributions.

The County shall contribute amounts deemed necessary to meet its obligations under the Plan. Contributions to the Plan for the Plan Year shall include amounts determined by the Benefits Enrollment Application and Salary Reduction Agreement entered into by Participants for the Plan Year. Contributions to the Plan shall be made to, and all Plan assets shall be held in, such Benefits Accounts as the County deems appropriate.

4.2 Spending Credits.

Prior to the beginning of each Plan Year or a Participant's Entry Date, the County shall provide each Participant with an amount of Spending Credits according to the formula set forth by the Board of Supervisors prior to the beginning of the Plan Year. Each Participant shall elect Benefits (other than Compensation) available under the Plan and apply Spending Credits towards the cost of the elected Benefits by executing a Benefits Enrollment Application and returning it to the Plan Administrator. Spending Credits not applied by the Participant toward the cost of Benefits shall be paid as Compensation, but only if the Participant elects at least one of the Benefits and submits a Benefits Enrollment Application to the Plan Administrator.

Eligible Employees electing not to enroll in medical coverage are not eligible to receive Spending Credits unless they meet the rules regarding waiver eligibility stipulated in the Memorandum of Understanding or Management Resolution governing their bargaining unit. They must also provide evidence of medical coverage through their Spouses or other sources and sign a statement that they are enrolled and covered under another medical plan, within 60 days of the election.

The County shall provide Spending Credits for each Participant in the amount determined by the Board of Supervisors, based on the Participant's unit/classification. Included within the monthly Spending Credit amount is an amount that is designated as the County's monthly contribution toward the Public Employees' Medical Health Care Act ("PEMHCA") or the County's optional health plans, if any.

4.3 Change in Participant's/Eligible Employee's Benefits Enrollment.

No Participant shall be allowed to alter or discontinue the Participant's elected Benefits under the Plan during a Plan Year, and no Eligible Employee shall be allowed to alter an election of "no coverage" during a Plan Year, except when due to and consistent with a Status Change as outlined in Section 2.19 or in accordance with a special enrollment right under Section 3.8.

Upon the occurrence of a Status Change or a special enrollment right, the Participant or Eligible Employee may file a new Benefits Enrollment Application, which will serve to revoke the Participant's or Eligible Employee's previous Benefits Enrollment Application. The new Benefits Enrollment Application, if determined by the Plan Administrator to be timely submitted and consistent with the Status Change or special enrollment right, shall be effective prospectively (except for the retroactive enrollment right under Code Section 9801(f) that applies to a timely election made after a birth, adoption, or placement of a child for adoption) and apply only to those

Benefits accruing to the Participant, Spouse, or Dependents after the effective date of the new Benefits Enrollment Application.

With respect to a special enrollment right, "timely submitted" shall mean submitted no later than 60 days from the date of the occurrence of the special enrollment right, as determined by the Plan Administrator. With respect to a Status Change, "timely submitted" shall mean submitted no later than 60 days from the date of the Status Change. The Plan Administrator shall make the final determination regarding whether the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change or special enrollment right.

The Participant's Benefits Enrollment Application for a given Plan Year shall terminate and Benefits under the Plan shall cease upon the date a Participant is no longer eligible to participate under the terms of the Plan.

4.4 Increases or Decreases in Cost of Benefits.
Should a third party benefit provider, such as an insurance company, increase or decrease the cost of any Benefit during the Plan Year, any Participant participating in such Benefit shall have his/her salary reduction contributions increased or decreased automatically in an amount corresponding to such increase or decrease, unless such increase or decrease is "significant" in accordance with Section 2.19.

4.5 Maximum Contribution.
The maximum contribution any Participant can make under the Plan is an amount equal to the sum of the costs for each of the highest cost Benefits offered under the Plan plus the sum of the salary reduction contributions made to the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan.

4.6 Nondiscrimination.
The Plan is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and benefits in accordance with applicable provisions of the Code. Notwithstanding any other provision of the Plan, if the Plan Administrator determines at any time that the Plan, or any portion of the Plan, may fail to satisfy any nondiscrimination requirement imposed on the Plan, or such portion of the Plan, by the Code or any other applicable law, the Plan Administrator may take such action, as appropriate in the discretion of the Plan Administrator, to comply with the applicable requirement. Such action may include, without limitation, a modification of the elections of "highly compensated employees" or "key employees" (as defined in the relevant Section of the Code), without the consent of the affected individuals. In addition, if necessary to comply with the nondiscrimination provisions of Code Section 125, Plan benefits provided to regular part-time Employees and Plan benefits provided to regular full-time Employees shall be deemed to be provided by two separate plans.

4.7 Tax Treatment.
While it is County's intent that Benefits will be eligible for exclusion from the gross income of the Participant, the County cannot guarantee or ensure that any of the Benefits provided under the Plan will not be subject to income or other taxes, as further set forth in Section 7.15.

Furthermore, the County will not be liable for any income or other taxes imposed upon an Participant, Spouse, Dependent, or any other person by reason of any Benefits received under the Plan.

If any Participant receives one or more benefit payments under the Plan that are not for a "qualified benefit" as defined by Code Section 125, such Participant shall indemnify and reimburse the County for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such benefit payments. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the benefit payments had been made to the Participant as Compensation, plus the Participant's share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

ARTICLE V
PARTICIPANTS' BENEFIT ACCOUNTS AND PAYMENT OF BENEFITS

5.1 Participants' Benefit Accounts.

The Plan Administrator shall establish separate Benefits Accounts based on the Benefits elections made by each Participant. Contributions shall be credited to the proper Benefits Accounts of each Participant. Each Benefits Account shall be designated as a "Premium Account" or as a "Reimbursement Account". In no event shall a Participant be permitted to utilize the Benefit Accounts to pay for "nonqualified benefits", as that term is defined in and applicable to Code Section 125.

5.2 Premium Account.

A "Premium Account" is an account established with the intent of paying pre-tax for premium-type Benefits pursuant to an insurance policy issued by an insurance company; under a contract with a health maintenance, preferred provider, or point-of-service organization; or as employee contributions toward the cost of Benefits paid out of the general assets of the County to provide medical, dental, vision, or other Benefits as described in enrollment material.

5.3 Reimbursement Account.

A "Reimbursement Account" is an account established with the intent of providing reimbursement of allowable expenses pursuant to the Health Care Reimbursement Plan or Dependent Care Reimbursement Plan.

5.4 Payment of Benefits.

The Plan Administrator shall make the benefit payments authorized under the Plan other than insurance Benefits administered by a third-party benefit provider. Payments for the cost of insurance Benefits shall be made by the County (or the Plan Administrator) in a timely manner upon receipt of a premium notice from the benefit provider. In the event of the death of the Participant prior to the payment of any claims, payment shall be made in the following priority:

(a) Executor of the estate of the deceased Participant;

(b) Spouse;

(c) Family member held responsible for payment of deceased Participant's medical bills; or

(d) Spouse or Dependent with COBRA continuation rights.

5.5 Coverage Provided.

While an election for Benefits may be made under the Plan, the Benefits are not provided by the Plan. The provisions of each medical, dental, and vision Benefit available under the Plan are described in the individual benefit plan descriptions. Reimbursement-type Benefits are described in separate plan documents, which are attached to this document as Schedule A and Schedule B.

ARTICLE VI
PLAN ADMINISTRATION

6.1 Plan Administrator.
The Plan Administrator shall be responsible for the administration of the Plan.

6.2 Plan Administrator's Duties.
It shall be a principal duty of the Plan Administrator to see that the Plan is administered, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan, without discrimination among such persons. In addition to any rights, duties, or powers specified throughout the Plan, the Plan Administrator shall have such rights, duties, and powers as may be necessary to discharge its duties hereunder, including, but not limited to, the following:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures;

(b) To construe and interpret the Plan, to decide all questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision;

(c) To construe and interpret the Plan, to decide all questions of eligibility and participation, and to determine the Benefits to be covered by the Plan;

(d) To determine the amount, manner, and time for benefit payments under the Plan, and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;

(e) To prescribe and apply any rules or procedures to insure the orderly and efficient administration of the Plan, including procedures for making or changing elections;

(f) To determine the rights of any Participant, Spouse, Dependent, or beneficiary to Benefits or payments under the Plan;

(g) To develop appellate and review procedures for any Participant, Spouse, Dependent, or designated beneficiary denied Benefits or payments under the Plan;

(h) To prepare and distribute information explaining the Plan and the Benefits in such manner as the Plan Administrator deems to be appropriate;

(i) To request and receive from all Participants such information as the Plan Administrator shall determine to be necessary for the proper administration of the Plan;

(j) To furnish each Participant with such reports as the Plan Administrator deems to be reasonable and appropriate;

(k) To receive, review, and keep on file such reports and information concerning the Benefits as the Plan Administrator determines to be necessary and proper;

(l) To appoint or employ any agents, attorneys, accountants, or other parties (who may also be employed by the County) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing; the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by any such experts employed or engaged by the Plan Administrator.

The Plan Administrator is empowered to take any actions it sees fit to assure that the Plan complies with the nondiscrimination requirements of Code Section 125.

6.3 Information to be Provided to Plan Administrator.
The County, or any of its agents, shall provide to the Plan Administrator any employment records of any Eligible Employee. Such records shall include, but will not be limited to, any information regarding periods of employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant, Spouse, or Dependent or any other person entitled to Benefits under the Plan shall furnish to the Plan Administrator his/her correct post office address; his/her date of birth; the names, correct addresses, and dates of birth of any designated beneficiaries, with proper proof thereof; or any other data the Plan Administrator might reasonably request to insure the proper and efficient administration of the Plan.

6.4 Decision of Plan Administrator Final.
Subject to applicable state or federal law, and the provisions of Section 6.5, below, any interpretation of any provision of the Plan made in good faith by the Plan Administrator as to any Participant's rights or Benefits under the Plan is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as it considers equitable and practicable.

6.5 Review Procedures.
All eligibility and enrollment-related claims under the Plan shall be determined by the Plan Administrator, in its sole discretion.

With respect to the denial of any claim for Benefits paid for through a Premium Account or any claim for payments from an insurance company or other third-party benefit provider, the review procedures of the insurance company or other third-party benefit provider shall apply, as described in the individual benefit plan descriptions.

The review procedures for claims under the Health Care Reimbursement Plan shall be administered as follows. In cases where the Plan Administrator denies a Benefit or

reimbursement under the Plan for any claimant, the Plan Administrator shall furnish in writing to the claimant the reasons for the denial of the Benefit or reimbursement. The written denial shall be provided within 30 days of the date of the denial by the Plan Administrator. The written denial shall refer to the Plan section upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of its final decision on the reviewed claim.

The review procedures for claims under the Dependent Care Reimbursement Plan shall be determined by the Plan Administrator, in its sole discretion.

No claimant shall initiate any action or proceeding in any state or federal court of law or equity, or before any administrative tribunal, for a claim for Benefits or payments under the Plan until the claimant has first exhausted the review procedures as set forth above. Any lawsuit to recover Benefits or payments shall be filed within three (3) years of the date that the claimant has exhausted the above review procedures, unless an applicable state statute of limitations provides for a different period in which to file.

6.6 Rules to Apply Uniformly.

The Plan Administrator shall perform its duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

6.7 Employment of Assistants.

The Plan Administrator is authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Benefit provision.

6.8 Indemnity.

The County shall indemnify and hold harmless, to the extent allowed by law, any Employee designated by the County or the Plan Administrator to assist in the fulfillment of the administration of the Plan against claims resulting from any action or conduct relating to such administration, except for claims arising from gross negligence, willful neglect, or willful misconduct. In addition, the County agrees to pay any costs of defense or other legal fees incurred by any of the above parties relating to such actions, over and above those paid by any liability or insurance contract.

6.9 Plan Administrator Compensation; Plan Expenses.

The Plan Administrator shall serve without compensation. However, all reasonable expenses for Plan administration, including reasonable compensation for hired services, will be paid by the Plan.

6.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of a person, the Plan Administrator shall, to the extent that it deems it administratively possible and as otherwise permissible under the Code, cause to be allocated, cause to be withheld or accelerated, or otherwise make adjustment of such eligibility, participation, or amounts as it shall in its judgment accord to such person and to which such person is properly entitled under the Plan. Such action by the Plan Administrator may include the withholding of any amounts due to the Plan or the County. The ability of the Plan Administrator to make such corrections shall be based on several factors, including:

(a) The reasonableness of the mistake;
(b) Whether the mistake is discovered within a reasonable time after the beginning of the coverage period under the Cafeteria Plan;
(c) Whether the person has claimed other similar mistakes in prior coverage periods under the Cafeteria Plan; and
(d) Whether other persons have made similar mistakes in the past.

6.11 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data shall be available to any Participant or Employee at reasonable times during normal business hours at the business office of the Plan Administrator or by contacting the Plan Administrator.

ARTICLE VII
GENERAL PROVISIONS

7.1 Amendment and Termination.

The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, the County may amend or terminate the Plan at any time by legal action of the authorized agents of the County, subject to the limitation that no amendment shall change the terms and conditions of payment of any Benefit that a Participant, Spouse, Dependent, or designated beneficiary was or might have been entitled to under the Plan prior to the time of the amendment or termination. The County may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Code Section 125 or any other Code provision applicable to the Plan.

7.2 Nonassignability.

Any benefit payments to any Participants under the Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents, and designated beneficiaries. No benefit payment shall be voluntarily or involuntarily assigned, sold, or transferred.

7.3 Medical Child Support Orders.

The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which:

(a) Relates to the provision of child support related to health care Benefits for a child of a Participant;
(b) Is made pursuant to a state domestic relations law; and
(c) Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive health care Benefits under which a Participant or other beneficiary is entitled to receive benefit payments.

The Plan Administrator shall promptly notify the Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order ("QMCSO") and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant, and the claim review procedures of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the Benefits to be offered by the Plan.

Any such QMCSO must clearly specify the name and last known mailing address of the Participant, name and address of each alternate recipient covered by the order, a description of the Benefits to be provided by the Plan or the manner in which such Benefits are to be determined, the period of coverage that must be provided, and each Benefit to which such order applies.

Upon determination of a QMCSO, the Plan must recognize the QMCSO by providing Benefits for the Participant's child in accordance with such order and must permit the Participant to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment period restrictions.

7.4 Not an Employment Contract.

By creating the Plan and providing Benefits under the Plan, the County in no way guarantees employment for any Employee. Participation in the Plan shall in no way assure continued employment with the County.

7.5 Participant Litigation.

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees or any other person having or claiming to have an interest under the Plan shall not be necessary parties to such action or proceeding. The County, through its Risk Management department at P.O. Box 1210, Riverside, CA 92502, shall be the sole source for service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the County and any interested party to the Plan.

7.6 Addresses, Notice and Waiver of Notice.

Each Employee shall furnish the County with his/her correct post office address. Any communication, statement, or notice addressed to an Employee at his/her last post office address as filed with the County will be binding on such person. The County or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under the Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

7.7 Required Information.

Each Participant, Spouse, or Dependent shall furnish to the County such documents, evidence, or information as the County considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the County.

7.8 Severability.

In any case where any provision of the Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

7.9 Gender and Number.

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

7.10 Applicable Laws.

The Plan is governed by the Code. To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced, and administered according to the laws of the State of

California.

7.11 Trust Provisions.
In the event that the Plan Administrator determines, in its sole and absolute discretion, that the Plan is required by law to establish and maintain a trust to hold contributions by Participants or to make benefit payments, as defined under applicable law, the Plan Administrator may establish a trust for this purpose. Any interest earned on amounts placed in such trust shall be used for any purpose as set forth in the trust.

7.12 No Vested Rights.
To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or a Benefit, or acquire any right, title, or interest in or to any Benefit referred to or provided for in the Plan or any Benefit otherwise than by actual payment of such Benefit. Further, no person has any right, title, or interest in or to the assets of the County because of the Plan.

7.13 Misrepresentation or Fraud.
A person who receives a benefit under the Plan as a result of false information or misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

7.14 Force Majeure.
Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

7.15 No Guarantee of Tax Consequences.
Neither the County nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan or any Benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's income for federal, state, and/or local income tax purposes, and to notify the County if the Participant has reason to believe that any such payment treated by the County as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which the County had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the County, such Participant shall pay all such taxes (including any related penalties and interest) directly or reimburse the County for any such taxes (including any related penalties and interest) paid by the County.

7.16 Incorporation by Reference.
The County of Riverside Health Care Reimbursement Plan and The County of Riverside Dependent Care Reimbursement Plan, as each is amended from time to time, are hereby specifically incorporated into the Plan by reference. These documents will be incorporated into the Plan to the extent that such document references the Plan and specifies the ability to or specifies the ability to pay for Benefits on a pre-tax basis and contribute to the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account.

7.17 Responsibility for Health Care.
The provisions of any health Benefit program under the Plan shall not be construed to limit a Participant with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Participant and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Participant shall be solely responsible for deciding the health care that the individual receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits will be paid under the Plan and is not intended to be advice to an individual concerning that individual's health care treatment. Each Participant shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that individual.

Executed this __________ day of ___________________, ______________

COUNTY OF RIVERSIDE

____
Chairman, Board of Supervisors

FORM APPROVED COUNTY COUNSEL
BY: Lisa Sanchez 12/03/2020
LISA SANCHEZ DATE