THE COUNTY OF RIVERSIDE
HEALTH CARE REIMBURSEMENT PLAN

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ARTICLE I
INTRODUCTION

1.1 Creation and Title.
The County hereby amends its welfare benefit plan under the terms and conditions set forth in this document. The Plan is to be known as The County of Riverside Health Care Reimbursement Plan.

1.2 Effective Date.
The provisions of the Plan, as amended and restated, shall be effective as of January 1, 2005. The Plan was originally effective January 1, 2000.

1.3 Purpose.
The purpose of the Plan is to provide reimbursement for certain medical expenses of the Participants not otherwise covered by insurance or by a health plan sponsored by the County as Employer. The County intends that the Plan qualify as an accident and health plan under section 105(e) of the Code, and that the nontaxable benefits provided under the Plan be eligible for exclusion from Participants' income under section 105(b) of the Code.

ARTICLE II
DEFINITIONS

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

2.1 "Agreement to Participate" means the agreement evidencing an Eligible Employee's election to participate in the Plan and setting forth the amount of Health Care Reimbursement Benefits to be made available to the Participant for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.

2.2 "Benefits Enrollment Application" means the completion of paper forms and/or submission of electronic enrollment in which an Eligible Employee selects from the various benefits sponsored by the Employer, including coverage under the Plan. The Benefits Enrollment Application shall set forth the amount of Health Care Reimbursement Benefits to be made available for a Plan Year or portion of a Plan Year as reimbursement for Qualified Expenses.

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

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

2.5 "Dependent" means an individual who is a dependent within the meaning of section 152(a) of the Code as modified by Code sections 105 and 106 and respective Regulations thereunder, of a Participant in the Plan.

2.6 "Effective Date" of the Plan, as amended and restated, shall be January 1, 2005.

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

2.8 "Employee" means an individual who is a "regular employee", 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 Number 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.

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

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

2.11 "Health Care Reimbursement Benefits" means, for any Plan Year, the amount available to a participant as benefits in the form of reimbursements of Qualified Expenses.

2.12 "Health Care Reimbursement Benefits Account" means the account established by the Plan Administrator under the Plan for each Participant from which benefits in the form of reimbursements of Qualified Expenses shall be paid..

2.13 "Participant" means any Employee who has met the eligibility requirements of section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Agreement to Participate and Salary Reduction Agreement and Benefits Enrollment Application.

2.14 "Plan" means The County of Riverside Health Care Reimbursement Plan, as described herein.

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

2.16 "Plan Year" means the twelve (12) consecutive month period beginning on January 1st and ending December 31st.

2.17 "Qualified Expenses" means the medical expenses incurred during a Plan Year by a Participant, the Participant's Spouse, or the Participant's Dependents while the Participant is a Participant, otherwise allowed as a deduction for medical expenses under section 213(d) of the Code. For purposes of the Plan, an expense is incurred on the date when the underlying services giving rise to the medical expenses are performed and not on the date that the services are billed by the service-provider or paid by the Participant.

2.18 "Regulation" means any applicable regulation established by the U.S. Treasury that relate to benefit plans established under the Code.

2.19 "Salary Reduction Agreement" means the agreement by an Employee authorizing the Employer to reduce the Employee's Compensation while a Participant during the Plan Year for purposes of obtaining Health Care Reimbursement Benefits under the Plan.

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

2.21 "Status Change" means any of the following with respect to Plan benefits:

(a) Legal marital status. Events that change an 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 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 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 Employer 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 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 Employee, Spouse or Dependent.

(f) 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 ERISA) that requires accident or health coverage for the Employee's child or for a foster child who is a Dependent of the Employee, as defined in Code section 152 (except that any child to whom Code section 152(e) applies is treated as a dependent of both parents). The Plan shall change the Employee's election to provide coverage for the child if the order requires coverage for the child under the Plan; or permit the 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.

(g) Entitlement to Medicare or Medicaid. If an 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 Employee to make a prospective election change to cancel or reduce coverage of that Employee or Dependent under the Plan. In addition, if an 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 Employee to make a prospective election to commence or increase coverage of that Employee, Spouse or Dependent under the Plan.

(h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code section 125.

ARTICLE III
PARTICIPATION

3.1 Eligibility.

Each Employee, as defined in section 2.8 above, shall be eligible to participate in the Plan if:

(a) the Employee is eligible to participate in the County of Riverside Flexible Benefit Program; and

(b) if the Employee is represented for collective bargaining purposes by an association or union, that association or union adopts this Plan through a memorandum of understanding with the County

3.2 Commencement of Participation.

An Eligible Employee shall become a Participant in the Plan after completing the Plan Administrator's executed 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 Employee's initial election period, the remaining portion of the Plan Year that contains the Employee's Entry Date. As part of the Benefits Enrollment Application, the Participant shall also execute a Salary Reduction Agreement, which authorizes the Employer to withhold from the Participant's Compensation an amount the Participant elects to have contributed to the Plan. A Participant may not modify his Benefits elections at any time during the Plan Year except as provided under Section 4.3. If a Participant wants to change his elections for a forthcoming Plan Year, the Participant 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, which may be completed in paper or electronic form. 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. A Participant 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 County's Health Care Reimbursement Plan will be deemed to have elected not to participate for that Plan Year.

3.3 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 date the Participant dies, resigns, or terminates employment with the Employer, subject to the provisions of section 3.4;

(b) the date the Participant fails to make the required contributions under the Plan;

(c) the date the Participant ceases to be an Employee; or,

(d) the date the Plan terminates.

A Participant's Health Care Reimbursement Benefits Account will remain open for the remainder of the Plan Year in which termination occurs, but ONLY for reimbursement of Qualified Expenses incurred prior to the Participant's termination date unless the Participant elects to continue coverage as defined in section 3.5 below.

3.4 Participation by Rehired Employees.

If a terminated Employee is rehired by the Employer in the same Plan Year as the Plan Year in which he or she separated from service, such Employee may elect to resume participation in the Plan under the terms of the Salary Reduction Agreement and Benefits Enrollment Application in force on the date of termination of employment, to be effective for the remainder of the Plan Year.

3.5 COBRA Continuation Coverage.

Subject to any provision in the Code or Regulations governing COBRA Continuation Coverage to the contrary, COBRA type continuation shall be available to Participants to the extent required by law. Notwithstanding any other provisions in this Article III, any Participant, Spouse, or Dependent eligible for continuation coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended from time to time, shall be allowed to continue to participate in the Plan, so long as such Participant, Spouse, or Dependent complies with the provisions set out in COBRA.

The Employer shall adopt rules relating to continuation coverage, as provided under section 4980B of the Code 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.

3.6 Family Medical Leave Act.

Subject to any provision in the Code or Regulations governing Family Medical Leave Act (FMLA) coverage to the contrary, FMLA-type continuation coverage 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 the following:

(a) Pre-pay before commencement of leave through pre-tax Salary Reduction Agreement from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met.

(b) Pay as you go option. Participants may pay their share of Health Care Reimbursement Benefits on an after-tax basis on the same schedule as payments would be made if the employee were not on leave, or on a pre-tax basis to the extent that the contributions are made from taxable compensation, including cashing out of unused sick or vacation days due the employee during the leave.

(c) Catch-up option. Upon prior agreement between the Participant and the Employer, participation may continue during an unpaid leave. When the Participant returns to work, the Participant's benefit deductions will re-calculated and the balance of his or her Health Care Reimbursement Benefit election will be deducted equally among the number of remaining paychecks left in the Plan Year on a pre-tax basis. Alternatively, the benefit deduction amounts that would have been made had the Participant not been on leave will be held in arrears and deducted from the first paycheck the Participant receives after returning to work, on a pre-tax basis. If the Participant does not return to work, the Employer is entitled to recoup those payments for claims made against his or her Health Care Reimbursement Account for expenses incurred while the Participant was on an unpaid leave.

ARTICLE IV
BENEFITS

4.1 Provision of Benefits.

Benefits under the Plan shall take the form of reimbursement of Qualified Expenses incurred by a Participant, the Participant's Spouse, and the Participant's Dependents during the Plan Year. A Participant, or former Participant shall be entitled to benefits under the Plan for Qualified Expenses incurred only while a Participant, unless continuation coverage is elected pursuant to section 3.5.

4.2 Amount of Reimbursement.

A Participant shall be entitled to benefits under the Plan for a Plan Year in an amount that does not exceed the Participant's Health Care Reimbursement Benefits. The amount of a Participant's Health Care Reimbursement Benefits shall be uniformly available during the Plan Year.

4.3 Change in Participant Election.

A Participant may not change the amount of Health Care Reimbursement Benefits to be made available for a Plan Year during that Plan Year, except in accordance with the rules for changes in elections due to and consistent with a Status Change.

Upon the occurrence of a Status Change, the Participant may file a new Benefits Enrollment Application, which will serve to revoke the Participant'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, 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 after the effective date of the new Benefits Enrollment Application.

With respect to an election change under the special enrollment period provisions of HIPAA, "timely submitted" shall mean submitted no later than the last day of such special enrollment period. With respect to any other change in election, the Plan Administrator shall determine if the new Benefits Enrollment Application has been timely submitted consistent with the nature of the Status Change.

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 this Plan, except as provided for in section 5.4.

4.4 Nondiscriminatory Benefits.

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. The Plan Administrator may take such actions as excluding certain highly compensated Employees from participation in the Plan if, in the Plan Administrator's judgment, such actions serve to assure that the Plan does not violate applicable nondiscrimination rules.

4.5 Tax Treatment.

While it is County's intent that nontaxable benefits will be eligible for exclusion from the gross income of the Employee, the County cannot guarantee or ensure that any of the benefits provided under the Plan will not be subject to income or other taxes.

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

4.6 Maximum Benefits.

Notwithstanding any other provisions of this Plan, no Participant shall receive Health Care Reimbursement Benefits in excess of $15,000.00 per Plan Year.

ARTICLE V
FUNDING AND PAYMENT OF BENEFITS

5.1 Funding.

The Employer shall contribute amounts necessary to fund the Plan, as determined primarily by the amount of the Health Care Reimbursement Benefits to be made available for the Plan Year. Contributions to the Plan for the Plan Year shall include amounts determined by the Salary Reduction Agreements 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 accounts or funds as the Employer deems appropriate.

5.2 Participants' Accounts.

The Plan Administrator shall establish a separate Health Care Reimbursement Benefits Account for each Participant in the Plan. The Plan Administrator shall credit a Participant's Health Care Reimbursement Benefits Account with the amount of Health Care Reimbursement Benefits to be made available to the Participant pursuant to the Agreement to Participate and Benefits Enrollment Application. The Plan Administrator shall charge a Participant's Health Care Reimbursement Benefits Account in the amount of any reimbursements made to the Participant. The Plan Administrator may also establish a minimum reimbursement amount. Requests submitted below the established minimum reimbursement amount shall not be reimbursed during the Plan Year, including the grace period set forth in section 5.4, except when the reimbursement results in a zero balance.

5.3 Payment of Benefits.

Reimbursement shall only be made under the Plan on the basis of Qualified Expenses incurred by the Participant, the Participant's Spouse, or the Participant's Dependents, as presented to the Plan Administrator on a written form specified by the Plan Administrator and as evidenced by a written statement from a third party. It shall be the duty of the Plan Administrator to construe what are and what are not Qualified Expenses subject to reimbursement from a Participant's Health Care Reimbursement Benefits Account. If the Plan Administrator determines that an expense is a Qualified Expense, subject to reimbursement, the Plan Administrator shall reimburse the Participant for the Qualified Expense within a reasonable time. To make the determination that a Qualified Expense subject to reimbursement has been incurred, the Plan Administrator may require proper evidence of any or all of the following:

(a) the name of the person or persons from whom the expenses have been incurred;
(b) the nature of the expenses incurred;
(c) the date the expenses were incurred;
(d) the amount of the requested reimbursement; or,
(e) that the expenses have not been otherwise paid through an insurance program offered by the Employer or any other employer, or reimbursed from any other source.

The Plan Administrator shall be the sole arbiter of what constitutes a Qualified Expense subject to reimbursement under the Plan.

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/ domestic partner;
(c) Family member held responsible for payment of deceased's medical bills;
(d) Spouse of Participant with COBRA continuation rights.

5.4 Forfeiture of Benefits.

If, as of the end of the Plan Year, a Participant has not had the opportunity to incur Qualified Expenses equal to the amount in his/her Health Care Reimbursement Benefits Account, the Participant shall be given until the March 15 of the immediately following Plan Year in which to incur Qualified Expenses to submit for reimbursement against that remaining balance ("grace period"), up to a maximum of $5,000.00. For any Plan Year, claims for reimbursement of Qualified Expenses incurred either during the Plan Year or the grace period must be provided to the Plan Administrator no later than April 15th following the end of the Plan Year. Any remaining balance in the Participant's Health Care Reimbursement Benefits Account for that Plan Year shall be forfeited. Notwithstanding, Participants who terminate prior to the end of the Plan Year must submit outstanding claims incurred through their last day of employment, no later than the last day of the Plan Year. Upon forfeiture, the Participant's Health Care Reimbursement Benefits Account shall be reduced to zero (0). At the discretion of the Employer, forfeitures of benefits under the Plan may be reallocated to Participants in any reasonable manner. Forfeitures of benefits may also be applied towards the cost of administering the Plan. Forfeitures of benefits shall become the sole property of the Employer.

5.5 Annual Report to Participants.

On or before January 31, the Plan Administrator shall provide a written statement to each Participant (or former Participant) of the amount of reimbursements of Qualifying Expenses paid to the Participant (or former Participant) for the immediately preceding calendar year.

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.
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 interpret the Plan, to decide all questions of eligibility and participation, to determine the amount, manner, and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies, or omissions under the Plan;
(b) to adopt and apply any rules or procedures to insure the orderly and efficient administration of the Plan;
(c) to determine the rights of any Participant, Spouse, Dependent, or beneficiary to benefits under the Plan;
(d) to develop appellate and review procedures for any Participant, Spouse, Dependent, or beneficiary denied benefits under the Plan;
(e) to provide the Employer with such tax or other information it may require in connection with the Plan;
(f) to employ any agents, attorneys, accountants, or other parties (who may also be employed by the Employer) 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 such allocation or delegation and the acceptance thereof is in writing;
(g) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might insure the efficient administration of the Plan.

However, nothing in this section 6.2 is meant to confer upon the Plan Administrator any powers to amend the Plan or change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure or third-party benefit provider. Notwithstanding the preceding sentence, the Plan Administrator is empowered to take any actions he or she sees fit to assure that the Plan complies with the nondiscrimination requirements of section 105 of the Code.

6.3 Information to be Provided to Plan Administrator.
The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any Employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period 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 may 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 this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this 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 he or she considers equitable and practicable.

6.5 Review Procedures.

In cases where the Plan Administrator denies a benefit under this Plan for any Participant or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish, in writing, to said party the reasons for the denial of benefits. The written denial shall be provided to the party within thirty (30) days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code 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 one hundred and eighty (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 sixty (60) days of the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of his/her final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

6.6 Extensions of Time.

In any case where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any claimant may need to appeal a claim, upon proper application to the Plan Administrator.

6.7 Rules to Apply Uniformly.

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

6.8 Indemnity.

The Employer does hereby agree to indemnify and hold harmless, to the extent allowed by law and over and above any liability coverage contracts or directors and officers insurance, any officer or director of the Employer, designated by the Employer or the Plan Administrator who has been

employed, hired, or contracted to assist in the fulfillment of the administration of this Plan. In addition, the Employer agrees to pay any costs of defense or other legal fees incurred by any of the above parties over and above those paid by any liability or insurance contract.

ARTICLE VII
DISCLOSURE OF PROTECTED HEALTH INFORMATION

7.1 Definitions.

Whenever used in this Article VII, the following terms shall have the respective meanings set forth below.

(a) Plan Administration Functions—means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(b) Health Information—means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR §160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR §160.103) that 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.

(c) Individually Identifiable Health Information—means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(d) Summary Health Information—means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed:

(1) Names;

(2) Geographic information more specific than state;

(3) All elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) Other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) Facial photographs or biometric identifiers (e.g., finger prints); and

(6) Any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(e) Protected Health Information ("PHI")—means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

7.2 Disclosure of Summary Health Information.

The Plan may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

The Plan will disclose PHI to the Employer only in accordance with 45 CFR §164.504(f) and the provisions of this Article VII.

PHI disclosed to the Employer in accordance with this Article may only be used for the following permitted and required uses and disclosures:

(a) Claims Processing
(b) Plan Auditing
(c) Quality Assurance

7.3 Employer Certification and Responsibility.

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended.

Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in section 7.4 or as required by law;
(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in section 7.4;
(e) to make PHI available to individuals in accordance with 45 CFR §164.524;
(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR §164.526;
(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR §164.528;
(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request; and
(i) if feasible, to return or destroy all PHI received from the Plan that the Employer 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, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
(j) to ensure that adequate separation between the Plan and the Employer, as required by 45 CFR §164.504(f), is established and maintained.

7.4 Employees With Access to Protected Health Information.

The Plan will disclose PHI only to the following employees or classes of employees:

(a) The Human Resources Department, which has been designated the HIPAA Privacy and Compliance Office of the County;
(b) The County Information Security Officer;

(c) Any other individual who is under the control of the Employer and who receives PHI relating to the Plan in the ordinary course of business (within the meaning of 45 CFR § 164.504(f)(2)(iii)) and who has been designated, in writing, by the County's HIPAA Privacy and Compliance Office.

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

7.5 Noncompliance.

Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Article by individuals described in section 7.4 shall be addressed in compliance with the Health Privacy and Security Policy most recently adopted by the County Board of Supervisors.

7.6 Data Security Standards.

Effective April 21, 2005, the Employer, as plan sponsor, shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;
(b) Ensure that the adequate separation required by 45 CFR Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides this information 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.

All terms used but not otherwise defined in the Plan shall have the same meaning as those terms in 45 CFR Parts 160 and 164.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Amendment and Termination.

The Employer may amend or terminate this Plan at any time by legal action of the authorized agents of the Employer, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant or beneficiary was entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendment apply retroactively to the extent necessary so that the Plan remains in compliance with section 105 of the Code or any other provision of the Code applicable to the Plan.

8.2 Nonassignability.

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

8.3 Not an Employment Contract.

By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any Employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

8.4 Participant Litigation.

In any action or proceeding against the Plan, or the administration thereof, Employees or former Employees of the Employer 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 Employer, the Plan Administrator, or their designated representatives shall be the sole source of service of process against the Plan. Any final judgment which is not appealed or appealable shall be binding on the Employer and any interested party to the Plan.

8.5 Addresses, Notice and Waiver of Notice.

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

8.6 Required Information.

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

8.7 Severability.

In any case where any provision of this 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.

8.8 Applicable Laws.

The Plan is governed by the Code and the Regulations issued thereunder (as they might be amended from time to time). To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of California.

Executed this _____ day of _____, _____

Employer: COUNTY OF RIVERSIDE

_____

Chairman, Board of Supervisors