REGIONAL WATER AUTHORITY
CAFETERIA PLAN

The REGIONAL WATER AUTHORITY ("Employer") hereby establishes the REGIONAL WATER AUTHORITY CAFETERIA PLAN ("Plan"), effective July 1, 2019.

ARTICLE I
TITLE AND PURPOSE

This plan shall be known as the REGIONAL WATER AUTHORITY CAFETERIA PLAN. The purpose of the Plan is to furnish to eligible employees choices among certain Benefits provided by the Employer, so that employees may receive Benefits that best meet their individual needs. The Plan is intended to provide benefits in accordance with Sections 125 and 105 of the Internal Revenue Code, as amended, and the regulations issued thereunder, so that the Benefits that an Employee elects to receive under the Plan are eligible for exclusion from the Employee's income for federal income and employment tax purposes. The Employer shall offer at least one permitted taxable benefit and at least one nontaxable qualified benefit.

ARTICLE II
COMPONENT PLANS

The Benefits offered under this Plan are provided through separate Component Plans which are set forth in separate plan documents, group insurance policies or administrative service contracts and are incorporated herein and identified in Schedule "A" attached hereto. Schedule "A" shall be updated or revised as required after such time as the Board of Directors has approved any changes to the Benefits or Group Health Coverage Allowance pursuant to any resolution.

ARTICLE III
DEFINITIONS

The following words and phrases, when used herein, shall have the following meanings, unless a different meaning is clearly required by the context:

3.1 Administrator. "Administrator" means the Employer or any person or entity appointed by the Employer to administer this Plan on its behalf, as provided in Article X.

3.2 Benefit. "Benefit" means any of the qualified benefits and permitted taxable benefits which may be purchased under this Plan.

3.3 CalPERS. "CalPERS" shall refer to the California Public Employees' Retirement System created under the authority of the Public Employees' Retirement Law as provided under Section 20000 et. seq. of the California Government Code, as may be amended from time to time, and as administered by the CalPERS Board of Administration.

3.4 Code. "Code" means the Internal Revenue Code of 1986, as amended and regulations issued thereunder. References to any section of the Code include references to any comparable or succeeding provision of any legislation which amends, supplements or replaces such section.

3.5 Component Plan. "Component Plan" means any plan offering Benefits available under this Plan, as set forth in the separate plan documents.

3.6 Dependent. "Dependent" means the Spouse or Dependent of a Participant who is eligible to receive benefits under a Component Plan. Dependent shall also mean, as to health benefits offered under the Plan, a dependent eligible under Code Section 152, determined without regard to Code Section 152(b)(1), (b)(2) or (d)(1)(B) and any child (as defined in Code Section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained 27 years of age.

Notwithstanding the preceding, if a Component Plan permits a Participant to cover an individual other than the Participant's Spouse or Dependent (including a Participant's registered domestic partner as recognized by the State of California), the term Dependent as used throughout the Plan document shall also include such individual provided the benefit is treated as a taxable benefit in accordance with Section 7.5.

3.7 Effective Date. "Effective Date" means the date this Plan first becomes effective, which is July 1, 2019.

3.8 Employee. "Employee" shall mean all regular employees of the Employer who customarily work an average of thirty (30) hours per week or that must be enrolled in CalPERS although working less than thirty (30) hours per week. Hours worked on behalf of Sacramento Groundwater Authority shall be deemed as hours worked for the Employer for purposes of this Plan. Temporary or part-time employees who are normally scheduled to work less than thirty (30) hours per week are not eligible to participate, unless they must be enrolled in CalPERS.

3.9 Employer. "Employer" means the Regional Water Authority.

3.10 Entry Date. "Entry Date" means, for all newly hired Employees, the first day of the month following date of hire. In all other cases, the "Entry Date" shall mean the first day of each Plan Year.

3.11 ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, including all regulations issued thereunder.

3.12 FMLA. "FMLA" means the Family Medical Leave Act of 1993, as amended and including all regulations issued thereunder.

3.13 Group Health Coverage Allowance. "Group Health Coverage Allowance" shall mean an amount that is the lesser of: (i) the monthly premium for the Health Benefit Plan in which a Participant has enrolled in for the Plan Year; or (ii) the monthly maximum Employer contribution set forth in Schedule "A" that is provided solely for the purchase of health coverage under the Employer's group health plans offered through CalPERS.

3.14 Health Benefit Plan. "Health Benefit Plan" shall refer to the health benefit plan approved or maintained by the CalPERS Board of Administration, which is available to CalPERS members working within the State of California.

3.15 Leave of Absence. "Leave of Absence" means any absence of an Employee that is authorized by the Employer under the Employer's personnel policies, including any leave designated as FMLA Leave. Additionally, an Employee shall be subject to such rights and benefits for family or medical leave, as defined in the Family and Medical Leave Act of 1993 ("FMLA") and the California Family Rights Act of 1991 ("CFRA").

3.16 Open Enrollment Period. "Open Enrollment Period" means the period beginning at least thirty (30) days before the beginning of the next Plan Year and ending on any date preceding the commencement of the Plan Year, as determined by the Administrator. For a new Employee, "Open Enrollment Period" shall mean the period between the Employee's effective date of employment and the first day on which an Employee may become a Participant.

3.17 Participant. "Participant" means an Employee who becomes enrolled in the Plan pursuant to Article IV and Article V. "Participant" shall also mean a former Employee who elects to continue health coverage under the Plan. However, a former Employee shall not be eligible for the Group Health Coverage Allowance.

3.18 Period of Coverage. "Period of Coverage" generally means the Plan Year beginning on January 1 and ending on December 31. A Participant's Period of Coverage may be less than 12 months if a new Participant enters the Plan during the year or a Participant completes a permitted election change in accordance with Article V. A Participant's Period of Coverage shall also include continuation coverage elected by a terminated Participant or Qualified Beneficiary.

3.19 Plan. "Plan" means the REGIONAL WATER AUTHORITY CAFETERIA PLAN, set forth herein, including all subsequent amendments and modifications hereto.

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

3.21 Salary Reduction. "Salary Reduction" means the amounts paid into the Plan pursuant to elections made by the Participant to reduce his or her compensation for the purchase of Benefits elected by the Participant.

3.22 Short Plan Year. "Short Plan Year" shall mean a Plan Year that is less than twelve (12) months and that ends on the last day of the Plan Year. This Short Plan Year shall arise only in the following circumstances: (i) the initial Plan Year did not begin on January 1; or (ii) the Employer changes the Plan Year for a valid business purpose resulting in a Short Plan Year. In the event that a Short Plan Year is in effect, all references to "Plan Year" shall be replaced by "Short Plan Year" in all instances where it is appropriate.

3.23 Spouse. "Spouse" means the person to whom the Participant is legally married. "Spouse" shall not include an individual legally separated from a Participant under a decree of legal separation unless it is court ordered. Notwithstanding, a Participant's registered

domestic partner shall be entitled to and receive the same rights and coverage attributable to medical and health benefits offered under the Plan pursuant to the California Domestic Partner Rights and Responsibilities Act of 2003, provided that such benefits are treated as taxable benefits in accordance with Section 7.5.

3.24 Uniformed Services. "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

ARTICLE IV
ELIGIBILITY AND PARTICIPATION

4.1 Eligibility. Each Employee shall be eligible to participate in the Plan as of his or her Entry Date.

4.2 Participation. An Employee may become a Participant by completing and executing an election form and Salary Reduction Agreement, and by providing such other information as is reasonably required by the Employer as a condition of such participation. A Participant's election to participate in the Plan shall continue to be valid until expressly revoked or altered, as set forth in Article V. The Administrator shall continue to make Salary Reductions and the Participant shall be deemed to have selected the Benefits previously elected by Participant in subsequent Plan Years consistent with the Participant's most recent election form.

4.3 Recommencement of Participation. A former Participant may recommence participation in the Plan on his or her date of reemployment as an eligible Employee. If a former Participant is rehired by the Employer within thirty (30) days of his or her date of termination, such Participant shall not be permitted to submit a new election and his or her prior election shall be reinstated for the remainder of the Plan Year.

Any employee who returns to active employment within ninety (90) days of completing a period of absence from employment for duty in the Uniformed Services shall reenter the Plan upon reemployment. A Participant whose health coverage under the Plan is terminated on account of his or her being in Uniformed Service, and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the Uniformed Service.

4.4 Leave of Absence. A Participant shall not be disqualified from participating in the Plan with respect to health, dental and/or vision insurance ("Health Benefits") during the period in which the Participant is on an authorized protected Leave of Absence; provided that the Participant continues to have an employment relationship with the Employer and arranges to continue to pay his or her required costs, if any, for coverage for the Health Benefits elected for the Plan Year.

The Employer shall continue to provide the Group Health Coverage Allowance during the Participant's protected Leave of Absence irrespective of whether such

leave is paid or unpaid. For purposes of this Section 4.4, the term "protected" refers to leave taken pursuant to FMLA, CFRA or as a result of Uniformed Service.

A Participant who takes a paid Leave of Absence, shall have his or her share of the cost of Health Benefits deducted from his or her salary in the same manner as before the paid Leave of Absence was taken. However, a Participant who takes an unpaid Leave of Absence shall pay his or her required costs of coverage, if any, in the form provided in Section 7.2. Notwithstanding the preceding, a Participant taking an unpaid Leave of Absence may revoke his or her election to participate under any Health Benefits offered under this Plan, for the remainder of the Plan Year in which such unpaid Leave of Absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Administrator. If the Participant makes such an election, the Employer's provision of any allowances towards such Health Benefits, with respect to any protected Leave of Absence, shall also cease. Upon such Participant's return from his or her unpaid Leave of Absence, the Participant may then elect to be immediately reinstated in the Plan, on the same terms that applied to the Participant prior to the unpaid Leave of Absence taking into account any voluntary revocation with respect to the allocation of any allowances, and with such other rights to revoke or change elections as are provided to the Participants under the Plan.

Notwithstanding the foregoing, a Participant on either protected or unprotected Leave of Absence shall have no greater rights to benefits for the remainder of the Plan Year in which the Leave of Absence commences as other Participants.

4.5 Cessation of Participation. An Employee shall cease to be a Participant under this Plan and therefore, under each Component Plan, as of the earliest of:

(a) the date on which the Participant separates from service with the Employer; or

(b) the date on which the Administrator, on a consistent and uniform basis, deems the Participant has failed to make the required premium payments, including the Salary Reduction, for the elected benefits, as provided in Section 4.6; or

(c) the date on which the Participant is not eligible to participate in any of the Component Plans for which he or she wishes to make an election; or

(d) the date on which the Participant dies; or

(e) the date on which the Plan terminates.

4.6 Cessation of Required Contributions. A Participant's election to participate in the Plan may be terminated in accordance with Section 4.5(b) if the Participant fails to make the required premium payments with respect to the Benefit. In such case, that individual may not make a new benefit election for the remaining portion of the Plan Year.

4.7 Eligibility Under Component Plans. The eligibility of a Participant under a Component Plan shall be the same as set forth in this Article, unless otherwise specified in the

Component Plan under which a Participant has elected to receive benefits. Each Component Plan may provide more rigorous eligibility requirements which may cause a Participant to be ineligible to participate in a particular Component Plan, but continue to be eligible to participate in this Plan.

4.8 Coverage Level. A Participant shall be required to enroll only in the coverage level for which they are eligible. To the extent a change in family status causes the coverage level to which the Participant is eligible to decrease (i.e., from Employee plus 1+ to Employee Only), the Participant shall promptly inform the Employer. Any excess premiums paid by the Employer which are not subsequently reimbursed by CalPERS as a result of a Participant's delay, shall be reimbursed by Participant to the Employer unless the Employer waives this obligation.

ARTICLE V
ELECTIONS AND PROCEDURES

5.1 Election. Prior to the annual Entry Date (or mid-year Entry Date for newly hired Employees), there shall be an Open Enrollment Period during which the Employee may elect to participate in this Plan. The Administrator shall provide each Employee during each Open Enrollment Period with an election form and Salary Reduction Agreement which shall include, at a minimum, the following information:

(a) that the election form shall be completed and returned to the Administrator during the Open Enrollment Period; and

(b) that the election shall be effective on the Entry Date and continue in effect until the last day of the Plan Year for which the election is made, or until the Participant provides the Administrator with a new election form modifying or terminating his or her existing election; and

(c) that the election shall be irrevocable unless the Participant is entitled to change his or her election as provided in this Article V; and

(d) that the Participant's Salary Reductions shall be considered as Employer contributions used to pay for Benefits under the Plan.

5.2 Salary Reduction. Each Participant shall authorize the Employer to reduce his or her compensation by the amount needed for the purchase of Benefits, as elected by the Participant. The Administrator, may, in its discretion, establish a limit on the amount of Salary Reductions which a Participant may elect for the Plan Year or adjust any Salary Reduction election made under the Plan, to ensure that the Plan complies with the nondiscrimination provisions of Article IX. Salary Reductions shall be contributed to the Plan by the Employer on behalf of a Participant on a level and pro rata basis for each payroll period. In the event that an Employee ceases to be a Participant in this Plan, a Participant shall have no obligation to continue to make payments equal to the Salary Reduction

5.3 Election of Benefits. Each Participant shall submit to the Employer on the election form provided by the Administrator his or her election as to the Benefits to be provided

by the Employer and the portion of his or her Salary Reduction, if any, and Group Health Coverage Allowance which is to be applied to provide the Benefits selected, subject to the limitations on use set forth in this Plan. Notwithstanding the preceding, the Group Health Coverage Allowance may only be used to purchase group health coverage through CalPERS.

5.4 Failure to Make Initial Election. If an Employee who is first eligible to participate in the Plan fails to return the election form prior to the end of the Open Enrollment Period, the Employee shall be deemed to have elected not to participate in the Plan.

5.5 Opt Out; Waiver of Coverage. An employee may waive Health Benefit Plan coverage by providing the Administrator with evidence substantiating that he or she (and his or her Dependents, if applicable) is currently enrolled in an employer-sponsored group health plan or equivalent plan that, as determined by the Administrator will not: (i) adversely affect the Plan's affordable minimum value calculation, or (ii) run afoul of other applicable law. Evidence of other coverage must be provided each Plan Year.

(a) Waiver of Coverage. An Employee may waive Health Benefit Plan coverage upon completion of the following:

(1) The Employee shall provide the Administrator with reasonable evidence substantiating that the Employee, and all other individuals for whom he or she reasonably expects to claim a personal exemption deduction for the tax year to which the opt out payment applies (the "tax family"), is enrolled in an employer-sponsored group health plan that constitutes minimum essential coverage, and that such coverage will be effective during the applicable Period of Coverage

(2) The Employee declines coverage and agrees in writing to hold the Employer harmless for any consequences resulting in the waiver of such coverage.

(3) The Employee acknowledges in writing that the Employee shall not be permitted to enroll in the declined benefit option under the Plan until the next Open Enrollment Period, subject to the terms and restrictions of the insurance provider.

(4) An Employee shall be required to submit a new election and proof of alternate group health plan coverage for each Plan Year.

(b) Health Opt-Out Amount. In the event an Employee satisfies the requirements for waiving Health Benefit Plan coverage pursuant to Section 5.5(a), he or she shall receive a monthly amount as set forth in the Schedule of Benefits at Schedule "A" ("Health Opt-Out Amount") in cash. The cash payment shall be considered taxable compensation and shall be paid as set forth in Section 6.1(b). The Health Opt-Out Amount will not be provided if the Employer knows or has reason to know that the Employee or individual in the Employee's tax family will not have alternate group health plan coverage as required by Section 5.5(a). In the event of the Employee's termination of employment, he or she shall have no further right to receive any additional

monthly payments for the portion of the Plan Year after his or her date of termination of employment. An Employee receiving a Health Opt-Out Amount will not receive the Group Health Coverage Allowance from the Employer

5.6 Elections for Subsequent Plan Years.

(a) Open Enrollment Period. An Open Enrollment Period shall occur prior to the beginning of each Plan Year. During the Open Enrollment Period, a Participant who wishes to change his or her existing election shall have the opportunity to elect new or different coverage under the Plan effective for the subsequent Plan Year subject to the terms and conditions of the Component Plans.

(b) Failure to Reelect. If a Participant fails to reelect coverage but remains eligible to participate, the Participant shall be deemed to have elected the Benefits selected on the election for the preceding Plan Year and a Salary Reduction amount necessary to provide the same coverage.

(c) Continuation Coverage. During an Open Enrollment Period, any Participant, or a Qualified Beneficiary thereof, that has elected continuation of health coverage under the Plan, shall have the opportunity to elect new or different coverage under the Plan effective for the subsequent Plan Year. However, any such election shall be limited to health care options under the Plan.

5.7 Special Enrollment Period. In accordance with the Code Section 9801(f) and the regulations issued by the Department of Health and Human Services, an eligible Employee or Dependent who either incurs a loss of health coverage or becomes otherwise eligible for health coverage under this Plan shall be permitted to enroll for health coverage under the Plan in accordance with one of the special enrollment periods described in paragraphs (a) and (b) below.

(a) Loss of Health Coverage. An Employee who is otherwise eligible to enroll in the Plan but has not elected to participate in the Plan, or a Dependent of an Employee that is not enrolled but otherwise eligible under the Plan, shall be permitted to enroll for coverage under the Plan provided all of the following conditions are met:

(1) The Employee or Dependent was covered under another group health plan or had alternate health insurance coverage ("Prior Health Coverage") at the time coverage under this Plan was previously offered to the Employee.

(2) The Employee stated in writing at such time that Prior Health Coverage was the reason for declining enrollment.

(3) The Employee's or Dependent's Prior Health Coverage was either:

(i) under a continuation coverage provision and the coverage period was exhausted; or

(ii) was terminated as a result of loss of eligibility (including a result from a change in family status) or employer contributions toward such coverage were terminated.

(4) Under the terms of the Plan, the Employee requests such enrollment not later than thirty (30) days after the date of a special enrollment event or the date a certificate of group health coverage is provided following a termination of health coverage.

(b) Dependent Special Enrollment Period. Any Employee, regardless of whether said Employee is currently enrolled for health coverage under the Plan, who experiences an increase in the number of Dependents whether through marriage, birth, or adoption, shall be permitted to enroll for health coverage under the Plan. During the "dependent special enrollment period," Employee shall have the opportunity to enroll all other Dependents who are otherwise eligible for coverage, including the Employee if not enrolled, provided the Employee elects enrollment within thirty (30) days commencing on the later of: (i) the date dependent coverage is made available; or (ii) the date of the marriage, birth, adoption, or other event which results in the change of Dependents of Employee.

(c) State Premium Subsidy. Notwithstanding the thirty (30) day election period prescribed by subparagraphs (a) and (b) above, if an Employee or his or her Dependent becomes eligible to receive a state premium subsidy for a group health plan sponsored by the Employer, such Employee shall have the opportunity to enroll himself or herself or his or her affected Dependent for coverage in the Employer's health plan, provided the Employee elects enrollment within sixty (60) days of the date of the notice of qualification from Medicaid or the Children's Health Insurance Program ("CHIP").

5.8 Revocability of Elections. The Administrator shall permit a Participant to revoke an existing election or make a new election outside of the Open Enrollment Period for the remainder of a Plan Year only if the new election is for one of the following reasons:

(a) both the revocation and new election are made on account of and are consistent with a change in the Participant's family status, as set forth in Section 5.9;

(b) there is a significant change in the cost of coverage of the benefits previously elected by the Participant, as set forth in Section 5.11;

(c) both the revocation and new election are made on account of and pursuant to the terms of a "qualified medical child support order" as defined in ERISA Section 609, as set forth in Section 5.12; or

(d) the Participant, spouse or dependent becomes eligible for continuation coverage under Article VIII and the Participant desires to elect to increase the amount of his or her Salary Reduction in order to pay for the continuation coverage.

5.9 Participant Makes Incorrect Election. If a Participant does not elect the correct amount from his or her Salary Reduction to pay for coverage of the Benefits elected under the Plan, the Administrator is authorized to increase or decrease a Participant's election by the amount necessary to provide the Participant's elected coverage under the Plan.

5.10 Change in Family Status. A Participant may make a change in coverage during a Plan Year due to a change in family status, as set forth in this Section. A Participant must notify the Administrator and must complete a new election form to change coverage. The Participant's election shall only be deemed valid if the requested change in coverage is necessitated by and corresponds with the change in family status and is consistent with the terms and conditions of the affected Component Plan. This election shall be effective as of the first day of the month following the date the Participant provides the Administrator with a new election form reflecting the change in coverage due to a change in family status.

A change in family status shall include the following:

(a) a change in the Participant's marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

(b) a change in the number of dependents of a Participant (as defined in Section 3.17), including a birth of a child, adoption, placement for adoption, or death of a dependent;

(c) any change in the employment status of the Participant, spouse or dependent which results in that individual becoming or ceasing to be eligible under this Plan or other employee benefit plan maintained by the employer of the Participant, spouse or dependent, including a termination or commencement of employment; a strike or lockout; a commencement or return from an unpaid leave of absence (including leave taken under FMLA); a change in work site; or a reduction or increase in hours of employment (including a switch between part-time and full-time);

(d) a dependent satisfies or ceases to satisfy the eligibility requirements for coverage due to attainment of age, student status, or any similar circumstances as provided under the Component Plan under which the employee receives coverage;

(e) a change in the place of residence of the Participant, spouse, or dependent; and

(f) a Participant, spouse, or dependent becoming or ceasing to be entitled to coverage under Medicare or Medicaid.

To the extent the Code, and regulations issued thereunder, alters this definition of change in family status, this Section 5.10 is intended to be interpreted in accordance with any revised definition or interpretation.

5.11 Change in Cost of Benefit.

(a) Insignificant Change. If the cost of any Benefit offered under the Component Plans increases or decreases during the Plan Year, the Administrator may, on a reasonable and consistent basis, automatically increase or decrease a Participant's election by a corresponding amount of Salary Reductions to ensure that the Participant continues to receive the elected coverage under the Component Plans; provided, however, that if the increase or decrease is a significant change in cost, that the Participant shall be given the option to elect to change his or her Benefits.

(b) Significant Increase in Cost of Benefit. If the cost of a Benefit option (other than a Component Plan which provides for the reimbursement of expenses) significantly increases during a coverage period, all affected Participants may make a corresponding change in their benefit election under the Plan. Changes that may be made include the following:

(1) In the case of a Benefit option which has experienced a significant decrease in cost, a Participant may make a prospective change to an election to commence participation in that Benefit option.

(2) In the case of a Benefit option that has experienced a significant increase in cost, a Participant may change an election to terminate such coverage and either, elect prospective coverage under another Benefit option providing similar coverage or drop coverage if no other Benefit option providing similar coverage is available.

For purposes of this Section 5.11(b), a "cost of increase or decrease" refers to an increase or decrease in the amount of the Salary Reductions contributed by a Participant under the Plan, whether that increase or decrease results from an action taken by the Employee (such as switching between full-time and part-time status) or from an action taken by the Employer (such as reducing the amount of Employer contributions for a class of Employees).

5.12 Significant Change in Coverage of Component Plan Benefit.

(a) Significant Curtailment Without Loss of Coverage. If a Participant or a Participant's Spouse or Dependent experiences a "significant curtailment of coverage" under a Benefit option that is not a loss of coverage, including a significant increase in the deductible, co-payment, or the out-of-pocket cost sharing limit under a group health plan; the Participant may revoke his or her election for such coverage and prospectively elect to receive coverage under another Benefit option providing similar coverage. For this purpose, coverage under a Component Plan is "significantly curtailed" only if there is an overall reduction in coverage provided under the Component Plan so as to constitute reduced coverage generally. In this regard, the loss of one particular physician in a health care provider network in most cases will not qualify for a significant curtailment of coverage under this Section.

(b) Significant Curtailment With Loss of Coverage. If a Participant or a Participant's Spouse or Dependent experiences a significant

curtailment of coverage that is a "loss of coverage" under a Benefit option, the Participant may revoke his or her election for such coverage and elect either to receive coverage under another Benefit option providing similar coverage or to drop coverage if no other Benefit option providing similar coverage is available under the Plan. For this purpose, a "loss of coverage" means a complete loss of coverage under a benefit package option or other coverage option, including the elimination of a benefits package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation under a group health plan. In this regard, each of the following is considered to be a "loss of coverage" under this Section:

(1) a substantial decrease in the medical care providers available under the Benefit option (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);

(2) a reduction in the benefits for a specific type of medical condition or treatment with respect to which a Participant or the Participant's Spouse or Dependent is currently in a course of treatment; or

(3) any other similar fundamental loss of coverage.

(c) Addition or Improvement of Benefit Option. If during the Plan Year, a Component Plan adds a new benefit package option or other coverage option, or if coverage under an existing option is significantly improved, any Participant or Employee, who is otherwise eligible to participate in the Plan, may revoke their election under the Plan for the Plan Year and make an election on a prospective basis for coverage under the new or improved benefit option.

(d) Change In Coverage Under Another Employer Plan. A Participant, or an Employee who is otherwise eligible to participate in the Plan but has elected not to participate, may make a prospective election change that is on account of, and consistent with, a change made under another employer plan (including a plan of the Employer or another employer) by the Employee or the Employee's Spouse or Dependent, provided the other employer plan allows participants to make an election change that would be permitted under the rules of Treas. Reg. §1.125-4(c) and as provided in this Plan.

5.13 Qualified Medical Child Support Order. A Participant may make a change in coverage during a Plan Year to provide health coverage under the Plan for Participant's child or legal dependent pursuant to the terms of a judgment, decree, or order resulting from a family law proceeding, including a "qualified child support order" as defined under ERISA Section 609, requiring Participant to provide health coverage for the child. The Participant may also make a change which cancels health coverage for the Participant's child or dependent provided the order requires the spouse, former spouse, or other individual to provide health coverage for the child.

5.14 Use of Electronic Medium for Participant Notices and Elections.

(a) Definition of Electronic Medium. "Electronic Medium" means an electronic method of communication between the Administrator (or its designated representative) and Employee thereby allowing each party to send and receive notices and elections through the same medium. The only form of electronic communication permitted by the Plan shall be via electronic mail on the Employer's network or intranet, through an interactive website, or to a private e-mail address supplied to the Employer by the Employee for communication purposes. The electronic medium must be designed so that the information provided is no less understandable to the receiving party than a written paper document. The electronic medium shall be designed to alert the Employee, at the time a notice is provided, to the significance of the information in the notice (including identification of the subject matter of the notice), and provide any instructions needed to access the notice, in a manner that is readily understandable. The electronic medium shall be designed to preclude any person, other than the appropriate individual, from making a Participant election, such as Salary Reduction Agreement, or accessing individual participant account information.

(b) Disclosure and Consent Requirements.

(1) Disclosure Statement. Prior to electronically transmitting any consent or notice to the Employee, the Administrator shall provide a statement which contains the following: (i) informs the Employee of the right to receive a paper document of the notice or other Plan-related material either prior to or after giving consent to electronic transmission; (ii) informs the Employee of the right to withdraw his or her consent at any time and the procedures for withdrawal, including any conditions or consequences arising from such withdrawal; (iii) describes the scope and duration of the consent as it relates to various plan transactions; (iv) describes the procedures for updating Employee contact information; and (v) describes the hardware or software requirements needed to access and retain the notice.

(2) Consent. The Administrator shall be exempt from the consent requirements of Section 101(c) of the Electronic Signatures in Global and National Commerce Act ("E-SIGN") provided the Electronic Medium used to provide notices and Plan-related material is a medium that the Employee has the effective ability to access and the Employee is advised, each time a notice is transmitted, that he or she can request to receive the notice in paper form at no charge. The form of Electronic Medium utilized by this Plan shall be through an interactive website requiring the Employee to register an e-mail address for communication purposes.

(3) Changes in Hardware or Software Requirements. In the event of any changes in the hardware or software requirements needed to access the Electronic Medium, the Administrator, or its designated representative, shall provide a statement to each Employee of the revised requirements and the right to withdraw consent to receive electronic delivery of Plan-related materials without consequence.

(c) Participant Elections. The Administrator, or its designated representative, shall be permitted to electronically distribute participant elections by Electronic Medium. Each Employee who is provided with enrollment or election information via Electronic Medium will also be informed by the Administrator that he or she may receive a paper copy of the relevant documents upon request. A participant election will not be treated as being made available to an individual if such individual cannot effectively access the Electronic Medium for purposes of making the election. An election completed by an Employee via Electronic Medium shall be deemed as being provided in written form so long as the following requirements are satisfied:

(1) The Employee has a reasonable opportunity to review, confirm, modify or rescind the terms of the election before the election becomes effective;

(2) The Employee receives, within a reasonable time, a confirmation of the election either through written paper form or by electronic mail (e-mail); and

(3) Any permissible change to an Employee's election shall only be effective if made directly through the Employer.

(d) Timing and Content of Elections and Notices. The provisions of this Section 5.14 shall in no way affect or alter the timing or content requirements applicable to each individual notice or document.

ARTICLE VI
EMPLOYER'S ALLOWANCE

6.1 Group Health Coverage Allowance. The Employer shall contribute the Group Health Coverage Allowance to the Plan on behalf of each Participant. The Group Health Coverage Allowance shall be credited to each Participant as of the first day of each month in each Plan Year during which he or she is a Participant under the Plan and can only be used to purchase group health coverage through CalPERS. The Employer shall inform the Participant of the amount of the Group Health Coverage Allowance available for each Plan Year during the Open Enrollment Period. A Participant that does not enroll in a group health plan through CalPERS shall not receive the Group Health Coverage Allowance. However, a Participant that satisfies the requirements for waiving coverage pursuant to Section 5.5 shall receive the Health Opt-Out Amount as set forth in Schedule "A" in lieu of the Group Health Coverage Allowance.

(a) Designated Employer Contribution. A portion of the Group Health Coverage Allowance shall be designated as the Employer's contribution towards health coverage under the Public Employees' Medical and Hospital Care Act. The amount shall be determined pursuant to Section 22892(b) of the California Government Code in accordance with the Employer's resolution on file with CalPERS.

(b) Special Rule Regarding Opt-Out Amounts. In the event a Participant elects to waive coverage in accordance with Section 5.5, he or she shall receive the

Health Opt-Out Amount, if applicable, in the amount set forth on Schedule "A". The Participant shall receive this amount as taxable cash compensation. The taxable cash compensation shall be pro-rated by the Employer and paid each payroll period.

6.2 Nature of Salary Reduction and Group Health Coverage Allowance. No money shall actually be allocated to any account(s) on behalf of Participants. Salary Reduction amounts and the Group Health Coverage Allowance credited to a Participant shall be of a memorandum nature, the amount of which is maintained by the Administrator for accounting purposes and shall not be representative of any identifiable trust assets.

ARTICLE VII
FUNDING AND AVAILABLE BENEFITS

7.1 Funding. The Benefits provided herein shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of compensation as a Participant elects to forego pursuant to his or her Salary Reduction election and the amount contributed by the Employer as the Group Health Coverage Allowance.

7.2 Payment of Contributions While on an Unpaid Leave of Absence. Upon a Participant taking an unpaid Leave of Absence, either protected or unprotected, each Health Benefit elected by the Participant shall continue during the Leave of Absence for a period not longer than the authorized Leave of Absence period as determined by the Administrator, unless otherwise revoked by the Participant. During the unpaid Leave of Absence, the Participant shall be responsible for making the Participant's required contributions, if any, for such Health Benefits during the period of the Leave of Absence on an after-tax basis as due ("Pay-As-You-Go"). Contributions under the Pay-As-You-Go Option may also be paid on a pre-tax basis from taxable compensation such as vacation pay or sick pay provided such payment will not defer compensation to a subsequent Plan Year. Payments shall be made on the same schedule as payments would have been due if the Participant had not been on Leave of Absence. Failure to pay the Participant's required contribution in the timeline prescribed will result in cancellation of the Health Benefit.

7.3 Uniformed Service Under USERRA. In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), a Participant who is absent from employment with the Employer on account of being in the Uniformed Services as defined in Section 3.24, may elect to continue participation in the Plan. The coverage period shall extend for the lesser of eighteen (18) months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions to pay for benefits elected during the period during which he or she is in Uniformed Service. The manner in which such payments are made shall be determined by the Administrator, in a manner similar to the payment of contributions with respect to a Leave of Absence.

7.4 Provision of Benefits. The Employer shall provide those Benefits elected by a Participant on his or her election for any Period of Coverage in accordance with such election. The Benefits shall be provided pursuant to the terms and conditions of the Component Plans, where applicable, as shall be set forth from time to time in the individual Component Plan documents; provided, however, that the terms and conditions of the Component Plans are not

inconsistent with the terms and conditions of this Plan. No Benefit under the Plan shall be paid in any manner that defers the receipt of compensation beyond the last day of the Plan Year.

7.5 Taxable Benefits. If offered by the Employer, Employees shall be permitted to elect to receive certain permitted taxable benefits. An Employee receiving such benefits shall be treated as having received, at the time that the benefit is received, cash compensation equal to the full value of the benefits and then subsequently purchasing the benefits with after-tax Employee contributions. For example, the Employer may allow Participants to elect health coverage under the Employer's group health plan for an individual who is not the Spouse or Dependent of the Participant; provided, however, that the fair market value of such health coverage is included in the Participant's W-2 income.

ARTICLE VIII
CONTINUATION COVERAGE

8.1 In General. The following provisions shall apply to Benefits provided to eligible Employees and to their eligible dependents under the Plan, but only to the extent that the Benefits selected pertain to health care coverage providing medical, surgical or hospital benefits and to plans providing ancillary medical coverage such as dental, vision or prescription drug benefits. This coverage shall be continued pursuant to the federal continuation coverage provisions of the Public Health and Safety Act ("PHSA"), pursuant to 42 U.S.C. § 300bb.

8.2 Definitions. For purposes of this Article VIII, the following words and phrases are intended to supplement, and in some instances replace, the defined terms listed generally in Article III and to the extent of any conflict between the terms set forth herein and those of Article III, the defined terms set forth herein shall control:

(a) "Dependent" means an individual who meets the definition of dependent under the participating Employer provided health plan covering the eligible Employee. No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by the Employer, dependent children may be covered by either spouse, but not by both.

(b) "Election Period" means the sixty (60) day period during which a Qualified Beneficiary who would lose coverage as a result of a Qualifying Event may elect continuation coverage. This sixty (60) day period begins not later than the date of termination of coverage as a result of a Qualifying Event and ends not earlier than the sixty (60) days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

(c) "Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

(d) "Qualified Beneficiary" means an individual who, on the day before the Qualifying Event, is covered under this Plan as the covered Employee, Spouse or Dependent. Qualified Beneficiary shall include a child who is born to (or placed for adoption with) a covered Employee during the coverage

period. The term Qualified Beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and Section 861(a)(3)). The term Qualified Beneficiary also does not include a covered Employee's domestic partner regardless of whether such person was a covered dependent under the Plan prior to the Qualifying Event. If an individual is not a Qualified Beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

(e) "Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage for a Qualified Beneficiary:

(1) the death of the covered Employee;

(2) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered Employee's employment;

(3) the divorce or legal separation of the covered Employee from such covered Employee's spouse;

(4) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act ("Medicare"); or

(5) a dependent child who ceases to be a dependent child under the terms of this Plan.

8.3 Continuation Coverage. To the extent required by Section 8.1 above, a Qualified Beneficiary who would lose health coverage under this Plan as a result of a Qualifying Event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a Qualified Beneficiary who is a covered Employee or spouse of the covered Employee will be deemed to include an election for continuation coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event.

If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage (i.e., single, family, etc.).

8.4 Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a Qualifying Event has not occurred as of the

time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

Continuation coverage available to a Qualified Beneficiary under this provision shall apply only to the type and level of health coverage under the Plan that a Qualified Beneficiary was actually receiving on the day before the Qualifying Event. The Qualified Beneficiary may not change his or her election except as otherwise provided under Sections 5.6(c) and 5.8(d).

8.5 Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event and ending not earlier than the earliest of the following:

(a) Initial 18-Month Coverage Period. If the Qualifying Event is a termination of employment (other than for gross misconduct) or a reduction in employment hours of a covered Employee, the coverage period for the Employee and his or her dependents shall extend for eighteen (18) months after the date of the Qualifying Event;

(b) Disability Extension. The initial eighteen (18) month coverage period described in (a) above may be extended to twenty-nine (29) months after the date of the Qualifying Event in the event the Qualified Beneficiary was disabled upon termination of employment or during the first sixty (60) days of continuation coverage. The Qualified Beneficiary must provide the Administrator with notice of a disability determination made by CalPERS within sixty (60) days of the disability determination and prior to the expiration of the initial eighteen (18) month continuation period provided in (a) above to become eligible for this extension of continuation coverage.

(c) Extension of Coverage Period. The initial eighteen (18) month coverage period described in (a) above may be extended to thirty-six (36) months after the date of the Qualifying Event upon the occurrence of a second Qualifying Event prior to the expiration of the initial eighteen (18) month coverage period. The Qualified Beneficiary must notify the Administrator of the second Qualifying Event within sixty (60) days of the date of the second Qualifying Event and prior to the expiration of the initial eighteen (18) month period. In no event shall continuation coverage extend for a period greater than thirty-six (36) months.

(d) 36-Month Coverage Period. In the case of any Qualifying Event causing the loss of coverage, except those Qualifying Events identified in (a) above, the coverage period for the Employee and his or her dependents shall extend for thirty-six (36) months after the date of the Qualifying Event.

8.6 Notification Requirements.

(a) Notification by Qualified Beneficiary. Each covered Employee or Qualified Beneficiary must notify the Employer of the occurrence of

a divorce or legal separation of the covered Employee from such covered Employee's spouse and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within sixty (60) days after the date of such occurrence. This sixty (60) day time limit shall only apply to those occurrences as described in this paragraph which occur after the date of the enactment of the Tax Reform Act of 1986.

(b) Notification by Employer. The Employer shall notify the Administrator within thirty (30) days of a Qualifying Event, as required by federal law.

(c) Notification to Qualified Beneficiary.

(1) The Administrator shall provide written notice to each covered Employee and spouse of such covered Employee of his or her right to continuation coverage under this provision upon commencement of coverage under a Component Plan providing health coverage, as required by federal law.

(2) The Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision within fourteen (14) days of receiving notice of the occurrence of a Qualifying Event, as required by federal law. If the Qualifying Event is the divorce or legal separation of the covered Employee from the covered Employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, the Employer shall only be required to notify a Qualified Beneficiary of his or her right to elect continuation coverage if the covered Employee or the Qualified Beneficiary notifies the Employer of such Qualifying Event within sixty (60) days after the date of such Qualifying Event.

Notification of the requirements of this provision to the spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

8.7 Termination of Continuation Coverage. The continuation coverage provided hereunder shall be terminated prior to the expiration of the coverage periods provided in Section 8.5 above upon the earlier of the following:

(a) with respect to continuation coverage under a medical spending account, the last day of the Plan Year in which the Qualified Beneficiary experiences the Qualifying Event;

(b) the date on which the Employer ceases to provide any group health plan to any Employee;

(c) the date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision provided the deficiency is not an "insignificant amount" as described in Section 8.8(d);

(d) the date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent. However, if the other group health plan has a preexisting condition limitation, continuation coverage under the Plan will not cease while such preexisting condition limitation under the group plan remains in effect (taking into account prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")); or

(e) the date on which the Qualified Beneficiary becomes entitled Medicare benefits.

8.8 Contribution.

(a) A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable premium required by the Employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the requirements of applicable federal law. A Qualified Beneficiary may elect to pay such premium in installments as indicated by the Employer.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made within thirty (30) days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) or (b) above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within forty-five (45) days of the date of the election.

(d) A premium payment received by the Employer which is deficient by an insignificant amount shall be treated as full payment of the premium amount. For purposes of this Section, an insignificant amount is an amount not greater than the lesser of (i) ten percent (10%) of the required amount; or (ii) fifty dollars ($50.00). Alternatively, in the event an Employer receives an insufficient payment premium, the Employer retains the option of taking steps to collect the deficient insignificant amount by notifying the Qualified Beneficiary of the deficiency and allowing thirty (30) days after date of the notice for payment of the deficiency.

8.9 Coordination with State Continuation Coverage. In the event a Qualified Beneficiary is entitled to less than thirty-six (36) months of federal continuation coverage as a result of a Qualifying Event, the Qualified Beneficiary will be notified prior to the expiration of federal continuation coverage if he or she is eligible to elect an extension of continuation coverage under the Plan for an additional period of up to thirty-six (36) months from the date of the Qualifying Event pursuant to the Section 1366.20 et. seq. of the California Health and Safety Code (the "California Continuation Benefits Replacement Act" or "Cal-COBRA Program").

A covered employee's dependent who, (1) on the day before the Qualifying Event, is covered under this Plan as the registered domestic partner of the covered

Employee and (2) loses health coverage under this Plan as a result of a Qualifying Event shall be entitled to state continuation coverage subject to the eligibility, election and contribution requirements set forth under the Cal-COBRA Program.

ARTICLE IX
DISCRIMINATION

9.1 Nondiscrimination Requirements. The Employer shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate in the Plan or as to contributions and Benefits provided under the Plan pursuant to Section 125 of the Code and the regulations. In addition, the Employer shall not discriminate in favor of Highly Compensated Individuals as to the actual operation of this Plan.

(a) Eligibility to Participate. The Plan shall not be considered discriminatory if the Plan benefits a group of employees who qualify under a reasonable classification established by the employer and the group of employees included in the classification satisfies the safe harbor percentage test or unsafe harbor percentage component of the facts and circumstances test in Treas. Reg. §1.410(b)-4(c) of the Code. The Employer is permitted to exclude the following employees in making this determination:

(1) Employees covered by a collectively bargained plan;

(2) Employees who are nonresident aliens and receive no earned income in the United States from the Employer; and

(3) former employees who have elected to extend health coverage under the Plan pursuant to Article VIII.

Notwithstanding, the Plan will not be considered discriminatory if all employees are permitted to participate.

(b) Benefit Availability and Participation. The Plan shall not be considered discriminatory if the Plan provides Benefits, including Employer contributions allocable to Benefits, which do not discriminate in favor of Highly Compensated Participants. Benefits shall be made available to all Employees on a uniform basis and each eligible Employee will be given an equal opportunity to make an election for Benefits. The Plan shall be considered discriminatory if the actual election or participation in the Plan by Highly Compensated Participants, including types of Benefits provided and utilization of Employer contributions for the selection of qualified Benefits, is disproportionate to the total number of non-Highly Compensated Participants for a Plan Year.

(1) Election of Benefits by Highly Compensated Participants. Qualified Benefits are disproportionately elected by Highly Compensated Participants if the aggregate qualified Benefits elected by Highly Compensated Participants, measured as a percentage of the aggregate

compensation of Highly Compensated Participants, exceed the aggregate qualified benefits elected by non-Highly Compensated Participants measured as a percentage of the aggregate compensation of non-highly Compensated Participants.

(2) Utilization of Employer Contributions by Highly Compensated Participants. Employer contributions are disproportionately utilized by Highly Compensated Participants if the aggregate contributions utilized by Highly Compensated Participants, measured as a percentage of the aggregate compensation of Highly Compensated Participants, exceed the aggregate contributions utilized by Non-Highly Compensated Participants measured as a percentage of the aggregate compensation of Non-Highly Compensated Participants.

(3) Safe Harbor for Health Benefits. If health benefits are provided under the Plan, excluding dental coverage and medical spending accounts, the Plan shall not be considered discriminatory as to the availability of Benefits and utilization of Employer contributions if –

(i) Employer contributions made on behalf of each Participant include an amount which equals one hundred percent (100%) of the cost of the health Benefit coverage of the majority of the Highly Compensated Participants similarly situated, or equals or exceeds seventy-five percent (75%) percent of the cost of the health Benefit coverage of the Participants (similarly situated) having the highest cost health benefit coverage under the Plan; and

(ii) Contributions or Benefits under the Plan in excess of those described in subparagraph (i) above bear a uniform relationship to compensation.

(c) Safe Harbor for Premium-Only-Plans. A premium-only plan is deemed to satisfy the nondiscrimination rules described in Section 9.2(b), as to the availability of benefits and contributions, for a Plan Year upon satisfaction of the nondiscrimination requirements for eligibility to participate described in Section 9.2(a).

(d) Definitions.

(1) Highly Compensated Individual. For purposes of this Section 9.1, "Highly Compensated Individual" shall mean (i) an officer of the Employer who is regularly and continuously involved in the business operations of the Employer; (ii) an individual that is "highly compensated;" or (iii) a spouse or dependent of a Highly Compensated Individual.

An individual is "highly compensated" if for the preceding Plan Year (or the current Plan Year in the case of the first year of employment) he or she received compensation from the Employer in excess of the amount specified in Section 414(q)(1)(B) of the Code ($125,000 for 2019). The Employer may also elect to identify a top-paid group for any Plan Year consisting

of the top twenty percent (20%) of the Employees when ranked on the basis of compensation pursuant to Section 414(q)(3)) of the Code.

A Highly Compensated Individual who elects to participate in the Plan may be referred to as a Highly Compensated Participant for purposes of this Article IX.

9.2 Annual Testing. The Employer shall perform nondiscrimination testing as of the last day of the Plan Year, taking into account all non-excludable Employees or former Employees who were employed during the Plan Year.

9.3 Avoiding Discrimination.

(a) Ability to Reject Election. If the Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Participants, the Administrator may, but shall not be required to, reject any Salary Reduction Agreement or reduce contributions or non-taxable benefits to assure compliance with the nondiscrimination requirements of Code Section 125. Any act taken by the Administrator pursuant to this Section shall be in a nondiscriminatory and uniform manner.

(b) Manner of Rejecting Election to Avoid Discrimination. In the event the Administrator determines that it is necessary to reject a Salary Reduction Agreement or reduce contributions or nontaxable benefits, the rejection shall be carried out as set forth in this paragraph. Nontaxable benefits of the affected Highly Compensated Participant who has elected the highest amount of nontaxable benefits shall be reduced until the discrimination tests set forth in Section 9.2 are satisfied or until the amount of his or her nontaxable benefit equals the nontaxable benefit of the affected Participant who has elected the second highest amount of nontaxable benefits. This process shall continue until the discrimination tests are satisfied. Any reduction made pursuant to this paragraph shall be made proportionately among noninsured benefits and once all noninsured benefits are expended, proportionately among insured benefits. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the general account.

ARTICLE X
ADMINISTRATION

10.1 Allocation of Responsibility for Administration.

(a) Designated Representatives. The Employer may appoint an individual or an administrative committee to serve at its discretion as Administrator. The Administrator shall have only those powers, duties, responsibilities and obligations as are specifically given to the Administrator under the Plan.

(b) Employer Responsibilities. The Employer shall have the sole responsibility for making the contributions provided for under Article VI and shall have the sole authority to amend or terminate, in whole or in part, the Plan at any time.

(c) Administrator's Responsibilities. The Administrator shall have the sole responsibility for the administration of the Plan, as set forth herein. The Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. The Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of another Employee. Neither the Administrator, nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in the Plan.

(d) Transfer of Duties. The Employer may, at any time, assign all or any portion of the Administrator's duties to a contracting third party.

10.2 Powers and Duties of Administrator.

(a) Powers and Duties Delegated to Administrator. The Administrator shall supervise the administration of the Plan. The Administrator shall be responsible for ensuring that the terms and conditions of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan without discrimination. The Administrator shall have full power to administer the Plan, subject to the applicable requirements of the law and any Administration Agreement executed by and between the Employer and the Administrator. For this purpose, the Administrator's powers shall include the following:

(1) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder;

(2) to prescribe the procedures for the Participants to follow in filing applications for benefits and to prepare forms to be used by the Participants;

(3) to prepare and distribute, in such manner as the Administrator determines appropriate, information explaining the Plan;

(4) to receive from the Employer, Participants, Participant's spouses and Dependents, and other persons such information as shall be necessary for the proper administration of the Plan;

(5) to furnish to the Employer and the Participants, upon request, annual reports detailing the administration of the Plan;

(6) to receive, review and keep on file records pertaining to the Plan, as the Administrator deems convenient and proper;

(7) to allocate its administrative responsibilities;

(8) to appoint or employ individuals and any other agents the Administrator deems advisable, including legal and actuarial counsel, to assist in the administration of the Plan;

(9) to adopt such rules as the Administrator deems necessary, desirable or appropriate, subject to applicable law. All rules and decisions of the Administrator shall be uniformly and consistently applied to all Participants in similar circumstances; and

(10) to take all other steps necessary to properly administer the Plan in accordance with its terms and conditions and the requirements of the applicable law.

(b) Powers and Duties Not Delegated to Administrator. The Administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan, except as may be expressly provided herein. Interpretations of the provisions of the Plan shall not be deemed to be additions, subtractions, or modifications of the Plan.

10.3 Nondiscriminatory Exercise of Authority. Whenever in the administration of the Plan any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

10.4 Incapacity of Participant. Whenever, in the Administrator's opinion, a person entitled to receive any payment of a benefit hereunder or an installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage the person's financial affairs, the Administrator may direct the Employer to make payments to such Participant or to such person or to the person's legal representative or to a relative or friend of such person on such person's behalf, or the Administrator may apply the payment for the benefit of such Participant in such manner as the Administrator considers advisable. Any payment of a benefit or installment in accordance with the provisions of this Section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

10.5 Indemnification of Administrator. The Employer agrees to indemnify any Employee serving as Administrator (including any Employee or former Employee who formerly served as Administrator), against any and all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is made in good faith pursuant to the provisions of the Plan and not as a result of the Administrator's gross negligence or willful misconduct.

ARTICLE XI
CLAIMS PROCEDURE

All claims for benefits that are provided through insurance contracts, whether such contracts are between the insurer and the Employer or the insurer and the Participant, shall be made by filing a claim for benefits in accordance with the claims procedure set forth under the insurance contract. The Employer does not have the authority or responsibility for processing, reviewing or paying such claims. All disputes regarding those claims shall be resolved in accordance with the procedure set forth in the separate Component Plan document concerning those benefits.

ARTICLE XII
AMENDMENTS, TERMINATION AND ACTION BY EMPLOYER

12.1 Action by Employer. Any action by the Employer under this Plan, including but not limited to, termination of this Plan, shall be by action of the Employer, or by any person or persons duly authorized by action of the Employer to act on its behalf.

12.2 Amendments. Subject to any applicable meet and confer laws, the Employer reserves the right to make, from time to time, any amendment or amendments to this Plan as it deems necessary or desirable, without retroactive effect, unless specifically permitted to comply with the law.

12.3 Right to Terminate. The Employer may terminate this Plan at any time subject to any meet and confer obligations. In the event of the dissolution, merger, consolidation or reorganization of the Employer, the Plan shall terminate unless the Plan is continued by a successor to the Employer in accordance with the Employer's procedures.

12.4 Plan Termination. Upon the termination of the Plan, the Administrator may determine the best method to make payments to the affected Participants.

ARTICLE XIII
HIPAA PRIVACY STANDARDS

13.1 Protection of Individually Identifiable Health Information. The Employer and the Plan have adopted policies and procedures ("Privacy Policy") for the sole and limited purpose of complying with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR § 164.102 *et seq.*, as amended (the "Privacy Rule"). The manner in which these provisions will be administered shall in no way affect, or be taken into account in determining, the benefits under the Plan with respect to any individual.

13.2 Definitions. The defined terms and phrases used in this Article shall carry the same meaning and intent set forth under the Privacy Rule, and in some instances may replace the defined terms listed generally in Article III and to the extent of any conflict between the terms set forth herein and those of Article III, the defined terms shall carry the meaning prescribed under the Privacy Rule.

13.3 Protected Health Information. For purposes of this Article XIII, Protected Health Information (or "PHI") means information that (a) 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; (b) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual); and (c) is limited to the information created or received by Business Associate, or is made accessible to Business Associate. Further, PHI means individually identifiable information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any form or medium. PHI excludes education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g, records described at 20 U.S.C. § 1232g(a)(4)(B)(iv), and employment records held by a covered entity in its role as employer.

13.4 Identity of Plan Sponsor. The Employer shall be the Plan Sponsor for purposes of the Privacy Rule when performing Plan administration functions or Plan Sponsor functions, when acting on behalf of the Plan with respect to its obligations under the Privacy Rule, and when acting on behalf of the Plan's participants and beneficiaries with respect to Participation and Enrollment Information. The Privacy Official shall act for the Plan Sponsor and shall be entitled to delegate its powers and responsibilities in accordance with its usual practices.

13.5 Responsibilities and Undertakings. The Plan Sponsor shall be responsible for making any necessary certifications to the Plan. Such certifications shall be delivered to the Plan's Privacy Official. The Plan Sponsor also undertakes and agrees that it:

(a) Shall not use or disclose any PHI except as to those uses specifically permitted under the Privacy Rule.

(b) Shall require any agents or subcontractors to whom it discloses PHI to agree to the same restrictions on the use and disclosure of PHI as apply to the Plan Sponsor;

(c) Shall not use or disclose PHI for any employment-related actions of Employer;

(d) Shall not use or disclose PHI in connection with any other benefits or benefit plan, program, or arrangement of Employer.

(e) Shall report to the Privacy Official any uses or disclosures of PHI inconsistent with the Privacy Policy of which it becomes aware.

(f) Shall make PHI available in accordance with an individual's right of access in accordance with the Privacy Policy.

(g) Shall make PHI available for amendment and shall incorporate amendments in accordance with the Privacy Policy.

(h) Shall make information available to provide any required accounting of disclosures of PHI in accordance with the Plan's Privacy Policy.

(i) Shall make available to the Secretary of Health and Human Services its internal practices, books, and records relating to the use and disclosure of PHI from the Plan for purposes of determining the Plan's compliance with the Privacy Rule.

(j) Shall, if feasible, return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible.

(k) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established.

13.6 Uses and Disclosures of Protected Health Information.

(a) Certification. The Plan, and any Health Insurance Issuer or Health Maintenance Organization with respect to the Plan, may disclose PHI to the Plan Sponsor only following receipt of the Plan Sponsor's certification that the Plan has been amended in accordance with the requirements of the Privacy Rule.

(b) Plan Administration. The Plan Sponsor shall be permitted to the limited use and disclosure of PHI for purposes of plan administration, including all Payment Activities and health care operations, as permitted under the Privacy Policy.

(c) Compliance with Privacy Rule. The Plan Sponsor shall be entitled to those uses and disclosures of PHI as permitted by the Privacy Rule to the extent necessary for compliance, including but not limited to any uses and disclosures permitted (1) without permission from an individual; (2) only with explicit or implicit authorization; or (3) because the PHI has been cleansed.

(d) Participation and Enrollment Information. Participation and Enrollment Information may be disclosed as necessary to the Plan Sponsor.

(e) Summary Health Information. Summary Health Information may be disclosed to the Plan Sponsor for the limited purpose of performing Plan Sponsor functions.

(f) Individuals With Access to PHI. The Privacy Official and his or her delegates, if any, are permitted to have access to PHI disclosed to or by the Plan. In addition, the Plan Sponsor shall designate the individual(s) or group(s) of individuals under the direct control of the Plan Sponsor who are permitted to have access to PHI disclosed by or to the Plan.

(g) Limitations on Disclosures of, Access to, and Uses of PHI. PHI may be disclosed from the Plan only for Plan Administration Functions

performed on behalf of the Plan, and the other purposes identified in the Plan's Privacy Policy.

ARTICLE XIV
GENERAL PROVISIONS

14.1 Written Plan. The Administrator shall, upon request, provide each Participant with a copy of the written Plan(s) detailing the benefits available to the Participant.

14.2 No Trust Fund Required. The Employer shall have no obligation, but shall have the right, to insure any benefits under the Plan or to establish any fund or trust for the payment of benefits under the Plan.

14.3 Insured Benefits. The Employer shall have no responsibility for the payment of any benefits covered under the Component Plans provided by policies of insurance.

14.4 Rights to Employer's Assets. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Employer and the Administrator shall not be liable therefore in any manner.

14.5 Nonalienation of Benefits. Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall not be recognized, except to the extent required by law. The Employer shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

14.6 Divestment of Benefits. Subject only to the specific provisions of this Plan, nothing shall be deemed to divest a Participant of a right to the benefit to which the Participant becomes entitled in accordance with the provisions of this Plan.

14.7 Discontinuance of Contributions. In the event of a permanent discontinuance of contributions to the Plan, all Participants shall receive any and all benefits to which they were entitled as of the date the discontinuance of contributions occurred.

14.8 Plan Interpretation. This Plan and the various Component Plans are intended to be read in conjunction with one another. However, to the extent of any conflict, the provisions of the Plan shall control, unless otherwise provided by Sections 125 or 105(b) of the Code or the regulations issued thereunder.

14.9 Governing Law. The Plan shall be administered in the State of California and its validity, construction, and all rights hereunder shall be governed by the laws of the State of California.

14.10 Severability. If any provision of the Plan shall be held invalid or unenforceable, the remaining provisions shall continue to be fully effective.

14.11 Gender and Number. Words used in the masculine, feminine, or neuter gender shall each be deemed to refer to the other whenever the context so requires. Words used in the singular or plural number shall each be deemed to refer to the other whenever the context so requires.

14.12 Headings. Headings used in the Plan are intended solely for reference and are not intended to explain, modify or place any construction on any of the provisions of the Plan. Any conflict between such headings and the text shall be resolved in favor of the text.

14.13 Successors and Assigns. The Plan shall inure to the benefit of and be binding upon the parties hereto, their successors and assigns.

14.14 Discharge of Employee. The adoption and maintenance of the Plan shall not be deemed to be a contract between the Employer and the Employee. Nothing herein contained shall be deemed to give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

14.15 Consolidation With Other Plan Documents. In the event the Plan merges or consolidates with, or transfers the assets and liabilities to, any other plan, no Participant herein shall, solely on account of such consolidation or transfer, be entitled to a benefit on the day following such event which is less than the benefit to which he or she was entitled on the day preceding such event. For the purpose of this Section, the benefit to which a Participant is entitled shall be calculated and based upon the assumption that a Plan termination and distribution of assets occurred on the day as of which the amount of the Participant's entitlement is being determined.

14.16 Counterparts. The Plan may be executed in an original and any number of counterparts by the Employer, each of which shall be deemed an original of one and the same instrument.

[Signatures appear on the following page.]

SCHEDULE "A"

SCHEDULE OF BENEFITS

as of July 1, 2019

The following Schedule of Benefits, which may be amended from time to time by the Employer, specifies the Benefits and the Component Plans which set forth the terms, conditions and limitations of the Benefits offered to Participants. The periods of coverage for the Component Plans shall be the same as the Plan Year of the Plan, unless specified otherwise.

The following definitions shall apply for purposes of this Schedule of Benefits. Capitalized terms not otherwise defined in this Schedule of Benefits shall be as defined in Article III of the Plan.

1. **Sacramento Region**. The term "Sacramento Region" shall refer to the region determined by CalPERS for purposes of setting health plan premium rates that includes the counties of Sacramento and Placer.

2. **Basic Plan**. The term "Basic Plan" shall refer to the plans offered by CalPERS under the Basic Monthly Rate category.

3. **Median Premium**. The term "Median Premium" shall refer to the premium of the Basic Plan in the Sacramento Region that falls directly in the middle of all the Basic Plans which are available to Employees. In the event that the number of Basic Plans is an even number, the Median Premium shall be higher of the two middle rates. For example, for the 2019 plan year, there are nine (9) Basic Plans in the Sacramento Region that are available to Employees. Of these, the rate for the BSC Access+ plan is the Median Premium.

<table>
<tr><th colspan="5">ALL PERSONNEL
as of July 1, 2019</th></tr>
<tr><td colspan="5">GROUP HEALTH COVERAGE - May use the Group Health Coverage Allowance plus any Salary Reduction</td></tr>
<tr><td>BENEFIT</td><td>EMPLOYEE GROUP</td><td colspan="3">MAXIMUM EMPLOYER CONTRIBUTION
The Group Health Coverage Allowance is determined pursuant to Section 3.13 of the Plan</td></tr>
<tr><td></td><td></td><td>Employee Only</td><td>Employee & 1 Dependent</td><td>Employee & 2+ Dependents</td></tr>
<tr><td>Any CalPERS Health Benefit Plan</td><td>All Employees</td><td>Median Premium for Employee Only Coverage

($881.01 per month for 2019)</td><td>Median Premium for Employee and +1 Coverage

($1,762.02 per month for 2019)</td><td>Median Premium for Employee and 2+ Coverage

($2,290.63 per month for 2019)</td></tr>
<tr><td colspan="5">OTHER AVAILABLE BENEFITS</td></tr>
<tr><td>Health Opt-Out Amount</td><td colspan="4">Employees opting out of Health Benefit Plan coverage pursuant to Section 5.5 of the Plan are eligible to receive 1/2 of the Maximum Employer Contribution for Employee Only per month ($440.50 for 2019). Employees receiving the Health Opt-Out Amount are not entitled to the Group Health Coverage Allowance.</td></tr>
</table>

CERTIFICATION OF REGIONAL WATER AUTHORITY TO REGIONAL WATER AUTHORITY CAFETERIA PLAN

The REGIONAL WATER AUTHORITY is the sponsor of the REGIONAL WATER AUTHORITY CAFETERIA PLAN. The Cafeteria Plan is a hybrid entity within the meaning of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which includes non-health care and health care components. The health care components of the Cafeteria Plan include the following separate group health plans:

- All group health plans offered by CalPERS and in accordance with PEMHCA

The Cafeteria Plan and the health care components included in the Cafeteria Plan (collectively, the "Plan") are group health plans within the meaning of HIPAA. The Plan and the Regional Water Authority desire to exchange health information protected under HIPAA for purposes related to administration of the Plan. The Regional Water Authority, acting in its capacity as plan sponsor of the Plan ("Plan Sponsor") makes the following certifications for purposes of administering the Plan as required by the "Standards for Privacy of Individually Identifiable Health Information," 45 CFR §164.102 et seq. (the "Privacy Rule"):

The plan document of the Plan incorporates the following provisions and Plan Sponsor agrees to:

- not use or further disclose any PHI received from the Plan (including any health insurance issuer or HMO with respect to the group health plan) except as permitted or required by the plan documents or required by law;

- ensure that any agents or subcontractors to whom it discloses any PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

- not use or disclose PHI for employment-related actions and decisions;

- not use or disclose PHI in connection with any other benefit plan, program, or arrangement of the Regional Water Authority except to the extent such other benefit plan, program or arrangement is part of an organized health care arrangement of which the Plan also is a part;

- report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures specified in the Plan of which it becomes aware;

- give individuals access rights to PHI in its possession in accordance with the policies and procedures of the Plan;

- permit individuals to request amendment of their PHI in the Plan Sponsor's possession, and to make any necessary amendments, in accordance with the policies and procedures of the Plan;

- make information available to provide any necessary accounting of disclosures of PHI in accordance with the policies and procedures of the Plan;

- make its internal practices, books, and records relating to the use and disclosure of PHI from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Rule;

- if feasible, to return to the Plan or destroy any PHI from the Plan that it maintains in any form, and shall retain no copies of the PHI when the PHI is no longer needed for the purpose for which disclosure was originally made. If it is not feasible to return or destroy the PHI, the Plan Sponsor agrees that it shall further limit any uses and disclosures to those purposes that make the return or the destruction of the information not feasible; and

- agrees to ensure that adequate separation between the Plan Sponsor and the Plan is established.