

REGIONAL WATER AUTHORITY RETIREE HEALTH PREMIUM REIMBURSEMENT PLAN

The REGIONAL WATER AUTHORITY (“Authority”) hereby establishes the REGIONAL WATER AUTHORITY RETIREE HEALTH PREMIUM REIMBURSEMENT PLAN (“Plan”) for the benefit of certain retirees described herein effective July 1, 2019.

ARTICLE I PURPOSE

This Plan shall be known as the REGIONAL WATER AUTHORITY RETIREE HEALTH PREMIUM REIMBURSEMENT PLAN. This Plan is created under the authority of Section 53201 of the California Government Code and is an “employee welfare benefit plan,” established to provide health and welfare benefits to certain retirees of the Authority. These benefits are to be provided through group contracts with third party insurers. The Plan is intended as an uninsured health reimbursement arrangement to provide reimbursement of health insurance premiums. The Plan is intended to qualify as an accident and health plan and a group health plan under applicable provisions of the Code, and as a health reimbursement arrangement. It is further intended that the benefits paid to eligible retirees be excluded from their gross income pursuant to Section 105(b) of the Code.

ARTICLE II DEFINITIONS

The following words and phrases as used in this Plan shall have the following meanings, unless a different meaning is plainly required by the context:

- 2.1 Authority. “Authority” shall refer to the REGIONAL WATER AUTHORITY.
- 2.2 Allowance. “Allowance” shall refer to the amount set forth at Schedule “A”.
- 2.3 Base Contribution Rate. “Base Contribution Rate” shall refer to the rate of contribution applicable to the Authority as determined under the provisions of Section 22892(b) of the California Government Code which is paid directly by the Authority to CalPERS on behalf of a Participant.
- 2.4 Benefits. “Benefits” shall refer to benefits available to Participants in accordance with Section 4.1 of this Plan.
- 2.5 Board. “Board” shall refer to the Board of Administration of CalPERS.
- 2.6 Board of Directors. “Board of Directors” shall refer collectively to the members of the board of directors of the Authority.

2.7 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 and as administered by the Board.

2.8 Code. “Code” shall mean the Internal Revenue Code of 1986, as may be amended from time to time.

2.9 Dependent Child. “Dependent Child” shall refer to a dependent child, as defined under the terms of the health benefit plan in which the Participant is enrolled in during the Plan Year.

2.10 Dependent Domestic Partner. “Dependent Domestic Partner” shall mean a Domestic Partner who meets the following five requirements: (1) Domestic Partner has the home of Participant as his or her principal abode and is a member of Participant’s household during the entire taxable year of Participant; (2) Domestic Partner’s gross income for the calendar year in which such taxable year begins is less than the exemption amount, as defined in Section 151(d) of the Code; (3) Domestic Partner receives more than half of his or her support from Participant for the year; (4) Domestic Partner is not a qualifying child, as defined in Section 152(c) of the Code, of any taxpayer for any taxable year beginning in the calendar year in which such taxable year begins; and (5) the relationship between Domestic Partner and Participant is not in violation of local law.

2.11 Domestic Partner. “Domestic Partner” shall mean a registered domestic partner of a Participant who has fulfilled the requirements provided in Section 297 of the California Family Code.

2.12 Effective Date. “Effective Date” shall mean July 1, 2019.

2.13 ERISA. “ERISA” shall mean the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

2.14 Health Benefit Plan. “Health Benefit Plan” shall refer to a health benefit plan approved or maintained by the Board, which is available to CalPERS members.

2.15 Participant. “Participant” shall refer to a Retired Employee that has satisfied the eligibility requirements of Section 3.1, has submitted an election form to the Plan Administrator in accordance with Section 3.2, and participates in a Health Benefit Plan.

2.16 Plan. “Plan” shall mean the REGIONAL WATER AUTHORITY RETIREE HEALTH PREMIUM REIMBURSEMENT PLAN, as may be amended from time to time.

2.17 Plan Administrator. “Plan Administrator” means the Authority or any person or entity appointed by the Authority to administer this Plan on its behalf.

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

2.19 Retired Employee. “Retired Employee” shall refer to an Employee of the Authority that has retired from service with the Authority through CalPERS. An employee is deemed to be “retired from service with the Authority” if his or her effective retirement date is within 120 days of separation from employment with the Authority and he or she is receiving a service or disability retirement allowance from CalPERS resulting from the individual’s service to the Authority. The Allowance for a Retired Employee shall be determined on the basis of the tier applicable to the Retired Employee as set forth in Schedule “A”.

2.20 Reimbursement Amount. “Reimbursement Amount” shall refer to the reimbursement by the Authority to a Participant for health insurance premiums actually paid by the Participant in an amount not to exceed the difference between the Allowance and the Base Contribution Rate. Such Reimbursement Amount is intended for the purpose of reimbursing a Participant for health insurance premiums paid by the Participant and shall only be paid upon the Authority receiving satisfactory substantiation of the Participant’s payment of such premiums.

2.21 Spouse. “Spouse” means a spouse by legal marriage of the Participant. “Spouse” shall not include an individual from whom a Former Employee is legally separated.

ARTICLE III ELIGIBILITY

3.1 Eligibility. This Plan shall cover all Retired Employees eligible under Tier I, Tier II or Tier III as defined in Schedule “A”. A Retired Employee who is eligible to participate in this Plan pursuant to this Section 3.1 shall be eligible to receive Benefits as of the later of the Effective Date or the date that he or she submits the election form required under Section 3.2. A Retired Employee who has met the foregoing eligibility requirements shall be referred to as Participant.

3.2 Participation. All eligible Retired Employees shall submit a duly completed election form to the Plan Administrator, in the form provided by the Plan Administrator, to commence participation in the Plan. Participants shall not be required to submit a subsequent election form prior to each Plan Year unless a Participant chooses to make a change in election in accordance with Section 3.3. A Participant’s election to participate in the Plan shall continue to be valid until expressly revoked or altered.

3.3 Change In Election. A Participant shall be permitted to revoke or modify his or her election of benefits upon the occurrence of a Qualifying Event (as defined in Section 6.2(d)) by submitting a completed election form to the Plan Administrator. All other election changes shall be accepted only during the annual open enrollment period as prescribed by the Plan Administrator.

3.4 Survivor’s Death Benefit Coverage.

(a) In General. The surviving Dependent Child, and Spouse or Domestic Partner of a Participant (“Survivor”) shall be eligible to continue receiving Benefits under this Plan following the Participant’s death if the Survivor was participating in the Plan as of the Participant’s date of death and the Survivor is eligible to enroll in a Health Benefit Plan. The Benefits available to a Survivor shall be based on the Benefits for which such Participant was

eligible prior to his or her death.

(b) Effect on Other Coverage. This survivor's benefit shall neither replace nor supplement any rights to continuation coverage available to the Survivor under a separate group health plan sponsored by the Authority.

(c) Effect of Remarriage or Subsequent Domestic Partnership. Upon the remarriage of a Survivor or upon the creation of a subsequent domestic partnership under Section 297 of the California Family Code between a Survivor and another individual, such Survivor receiving Benefits under this Section prior to such event may continue to be eligible for continued Benefits if such individual meets the eligibility requirements of CalPERS. Notwithstanding the preceding, the subsequent spouse or Domestic Partner of the Survivor, or any dependent child of the subsequent spouse or Domestic Partner, shall not be eligible to participate in this Plan or receive any benefits under this Plan.

(d) Effect of Employee's Death Prior to Eligibility. In the event of the death of an employee that would otherwise be eligible to participate in this Plan as a Retired Employee but for his or her death prior to his or her eligibility under this Plan, a Survivor shall be eligible to receive benefits under this Plan but only if he or she is eligible to enroll in a Health Benefit Plan.

3.5 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 IV BENEFITS AND CONTRIBUTIONS

4.1 Benefits. Each Participant shall be entitled to an Allowance from the Authority to be credited against the premium for the Health Benefit Plan in which the Participant enrolls in for the Plan Year, in the following amounts and payable in the following forms: (1) Base Contribution Rate payable by the Authority directly to CalPERS, and (2) Reimbursement Amount payable to the Participant. The combined Base Contribution Rate and Reimbursement Amount shall not exceed the Allowance. If a Participant enrolls in a Health Benefit Plan with a premium in excess of the Allowance, he or she will be responsible for the payment of any excess. Conversely, if a Participant enrolls in a Health Benefit Plan with a premium that is less than the Allowance, the Participant's Benefit shall be limited to the payment of such premium.

(a) Substantiation. The Reimbursement Amount is intended for the purpose of reimbursing a Participant for health insurance premiums actually paid by the Participant and shall only be paid upon the Agency receiving satisfactory substantiation of the Participant's payment of the premiums. The Agency shall obtain such substantiation by reviewing the monthly invoice that it receives from CalPERS. The Agency, or its designee, shall use this

information to determine the Reimbursement Amount.

4.2 Authority and Participant Contributions.

(a) Authority Contributions. The Authority shall bear the entire cost of providing the Benefits available under this Plan.

(b) Participant Contributions. There are no Participant contributions permitted to the Plan for Benefits provided under the Plan.

(c) No Funding Under Cafeteria Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions under a cafeteria plan be treated as Authority contributions to the Plan.

4.3 Taxable Benefits. Any Benefits provided to a Domestic Partner, other than a Dependent Domestic Partner, shall constitute wages of the Participant and shall be subject to inclusion in the gross income of the Participant.

ARTICLE V
ADMINISTRATION

5.1 Allocation of Responsibility for Administration.

(a) Plan Administrator. The Plan Administrator shall have only those powers, duties, responsibilities and obligations as are specifically given to the Plan Administrator under the Plan or under any administration agreement between the Plan Administrator and the Authority.

(b) Authority Responsibilities. The Authority shall have the sole responsibility for making the contributions provided for under Article IV 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 Plan Administrator shall have the sole responsibility for the administration of the Plan, as set forth herein. The Plan Administrator warrants that any directions given, information furnished, or action taken by him or her shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. The Plan Administrator shall be responsible for the proper exercise of his, her or 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 Plan Administrator nor the Authority makes any guarantee to any Participant for any loss or other event because of Participant's participation in the Plan.

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

5.2 Powers and Duties of Plan Administrator.

(a) Powers and Duties Delegated to Plan Administrator. The Plan Administrator shall supervise the administration of the Plan. The Plan 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 Plan 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 Authority and Plan Administrator. For this purpose, the Plan 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 Participants to follow in filing applications for Benefits and to prepare forms to be used by Participants;

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

(4) to receive from the Authority, Participants and other persons, such information as shall be necessary for the proper administration of the Plan;

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

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

(7) to allocate his, her or its administrative responsibilities;

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

(9) to adopt such rules as the Plan Administrator deems necessary, desirable or appropriate, subject to applicable laws. All rules and decisions of the Plan 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 applicable laws.

(b) Powers and Duties Not Delegated to Plan Administrator. The Plan 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 Benefits 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.

5.3 Indemnification of Employee Administrator. The Authority agrees to indemnify any employee serving as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator), against any and all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by Board of Directors) 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 Plan Administrator's gross negligence or willful misconduct.

5.4 Claims Procedure. All claims for benefits that are provided through insurance contracts, whether such contracts are between an insurer and the Authority or an insurer and Participant, shall be made by filing a claim for benefits in accordance with the claims procedure set forth under the insurance contract. The Authority 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 procedures set forth in the separate document concerning those benefits.

ARTICLE VI COBRA CONTINUATION COVERAGE

6.1 In General. This Article VI shall apply to Benefits provided to Participants 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 or prescription drug benefits. This coverage shall be continued pursuant to the continuation coverage provisions of the Public Health Service Act, as set forth in 42 U.S.C. §300bb-1 et seq. ("PHSA"), and any amendments thereto with respect to Participant and his or her Dependent Child, his or her Spouse or Dependent Domestic Partner. And with respect to Domestic Partners covered under this Plan and to the extent that it offers greater protection than PHSA for all other eligible individuals, continuation coverage shall be pursuant to the California Continuation Benefits Replacement Act, as set forth in the California Health and Safety Code §1366.20 et seq.

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

(a) Covered Individual. "Covered Individual" shall mean any individual who receives (or received) Benefits under the Plan as a Participant.

(b) Election Period. "Election Period" shall mean 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) Qualified Beneficiary. “Qualified Beneficiary” shall mean any individual who, on the day before a Qualifying Event is a beneficiary under the Plan as a (i) Participant, (ii) Spouse; (iii) Dependent Child, or (iv) Domestic Partner. Qualified Beneficiary shall also include a child who is born to (or placed for adoption with) a Covered Individual during the coverage period. The term Qualified Beneficiary does not include an individual whose status as a Covered Individual is attributable to a period in which such individual is a nonresident alien who received no earned income from the Authority which constituted income from sources within the United States (within the meaning of Code Sections 911(d)(2) and 861(a)(3)). 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.

(d) Qualifying Event. “Qualifying Event” shall mean any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage to a Qualified Beneficiary:

- (1) the death of the Participant; or
- (2) the divorce or legal separation of the Participant from his or her Spouse, or Domestic Partner with respect to state coverage.

6.3 Continuation Coverage. To the extent required by Section 6.1, 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 Individual 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 (e.g., single, family, etc.).

6.4 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 change his or her election in accordance with Section 3.3.

6.5 Coverage Period. For most Qualifying Events, the coverage under this provision will extend for a maximum period of thirty-six (36) months after the date of the Qualifying Event.

6.6 Notification Requirements.

(a) Notification by Qualified Beneficiary. Each Covered Individual or Qualified Beneficiary must notify the Plan Administrator of the occurrence of a divorce or legal separation of the Covered Individual from his or her Spouse or Domestic Partner within sixty (60) days after the date of such occurrence.

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

(c) Notification to Qualified Beneficiary.

(1) The Plan Administrator shall provide written notice to each Covered Individual of his or her right to continuation coverage under this Section upon commencement of coverage under a component plan providing health coverage, as required by federal law, or state law if applicable.

(2) The Plan 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 law. If the Qualifying Event is the divorce or legal separation of the Covered Individual from his or her Spouse or Domestic Partner, the Plan Administrator shall only be required to notify a Qualified Beneficiary of his or her right to elect continuation coverage if the Participant, or his or her Spouse or Domestic Partner, notifies the Plan Administrator 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 or Domestic Partner of a Participant shall be treated as notification to all other Qualified Beneficiaries residing with such Spouse or Domestic Partner at the time notification is made.

6.7 Termination of Continuation Coverage. The continuation coverage provided in this Article VI shall be terminated prior to the expiration of the coverage period provided in Section 6.5 upon the earlier of the following:

(a) the date on which the Authority ceases to provide any group health plan to any employee;

(b) the date on which Qualified Beneficiary fails to make timely payment, as set forth in Section 6.8(b), of the required contribution pursuant to this Article;

(c) the date on which 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); or

(d) the date on which Qualified Beneficiary becomes entitled to benefits under Medicare.

6.8 Contribution.

(a) A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable premium required by the Authority to the Plan Administrator 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 if permitted by the Plan Administrator.

(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 initial 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 Plan Administrator 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). Alternatively, in the event the Plan Administrator receives an insufficient premium payment, the Authority and/or the Plan Administrator retain 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 the date of the notice for payment of the deficiency.

ARTICLE VII HIPAA PRIVACY STANDARDS

7.1 Protection of Individually Identifiable Health Information. The Authority 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.

7.2 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 II and to the extent of any conflict between the terms set forth herein and those of Article II, the defined terms shall carry the meaning prescribed under the Privacy Rule.

7.3 Protected Health Information. For purposes of this Article VII, 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.

7.4 Identity of Plan Sponsor. The Authority 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.

7.5 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 the Authority.
- (d) Shall not use or disclose PHI in connection with any other benefits or benefit plan, program, or arrangement of the Authority.
- (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 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.
- (f) Shall ensure that adequate separation between the Plan Sponsor and the Plan is established.

7.6 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 Plan's 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 VIII
AMENDMENT; TERMINATION

8.1 Amendment. The Plan may be amended by the Board of Directors at any time and from time to time. This Plan may be amended by a written resolution adopted by a majority of the Board of Directors.

8.2 Termination. The Plan may be terminated at any time by the Authority. Termination of the Plan shall be effected by a written resolution adopted by a majority of the Board of Directors.

ARTICLE IX
MISCELLANEOUS

9.1 Non-Assignability and Facility of Payment. Benefits payable under the Plan are not in any way subject to the debts or other obligations of the persons entitled thereto and may not be voluntarily or involuntarily sold, transferred or assigned to any person or persons other than the provider or providers of such Benefits. When any person entitled to Benefits under the Plan is under a legal disability or, in the Plan Administrator's opinion, is unable to manage his or her affairs, then, to the extent permitted under the applicable group contract, the Plan Administrator may cause his or her Benefit to be paid to his or her legal representative for his or her benefit, or to be applied for his or her benefit in any other manner that the Plan Administrator may determine.

9.2 Mistake of Fact. Any misstatement or any other mistake of fact in any notice or other document filed with the Authority or Plan Administrator shall be corrected when it becomes known and proper adjustment made by reason thereof. Neither the Authority nor the Plan Administrator shall be liable in any manner for any determination of fact made in good faith.

9.3 Source of Payments. The Authority shall be the sole source of Benefits under the Plan. No Participant shall have any right to, or interest in, any assets of the Authority except as provided from time to time under the Plan, and then only to the extent of the Benefits which are payable under the Plan to such Participant.

9.4 Status of Benefits. The Authority believes that this Plan is written in accordance with Section 105 of the Code and that it provides certain benefits to Participants which are free from Federal income tax under the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

9.5 Applicable Law. Subject to the provisions of ERISA, which may be applicable and which provide to the contrary, this Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of California.

9.6 Employment Rights. Employment rights of an employee shall not be deemed to be enlarged or diminished by reason of the establishment of this Plan, nor shall any provisions of

this Plan be deemed to confer any right upon any employee to be retained in the service of the Authority.

9.7 Construction. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine or neuter gender, and the singular shall be deemed to include the plural, and vice-versa, unless the context clearly indicates to the contrary. The words “hereof,” “herein,” “hereunder” and other similar compounds of the word “here” shall mean and refer to the entire Plan and not to any particular provision or Section.

[Signatures Follow on Next Page]

SCHEDULE “A”
SCHEDULE OF BENEFITS
as of July 1, 2019

The following Schedule of Benefits, which may be updated or revised as required after such time as the Board of Directors of the Employer has approved any changes to the Allowance, specifies the Benefits offered to Participants.

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 II of the Plan.

1. State Contribution 100/90 Formula. “State Contribution 100/90 Formula” means 100% of the weighted average of the health benefits plan premiums for employees and annuitants enrolled for self alone plus 90% of the weighted average of the additional premiums required for enrollment of family members in the four health benefits plans that have the largest number of enrollments plus administrative fees and contingency reserve fund assessments as determined annually by CalPERS. The State Contribution 100/90 Formula is the formula used by CalPERS to determine the contribution base amount. This amount is published annually on the CalPERS website.
2. Tier I Retiree. “Tier I Retiree” means a Retired Employee who retired prior to September 1, 2007.
3. Tier II Retiree. “Tier II Retiree” means a Retired Employee who: (a) was hired prior to July 1, 2019, (b) retired on or after September 1, 2007, and (c) has at least five (5) years of CalPERS service credit accrued from service with the Authority and/or Sacramento Groundwater Authority *plus* at least five (5) years of additional CalPERS service credit accrued from service with the Authority and/or Sacramento Groundwater Authority or other CalPERS employers.
4. Tier III Retiree. “Tier III Retiree” means a Retired Employee who: (a) was hired on or after July 1, 2019 and (b) has at least five (5) years of CalPERS service credit accrued from service with the Authority and/or Sacramento Groundwater Authority *plus* at least five (5) years of additional CalPERS service credit accrued from service with the Authority and/or Sacramento Groundwater Authority or other CalPERS employers.

[Allowance Determined in Accordance with Following Tables]

Retiree Group	Allowance <i>as of July 1, 2019</i>																														
Tier I Retiree	The Allowance is \$400 per month																														
Tier II Retiree	<p>The Allowance is equal to an amount equal to the Applicable Percentage of the contributions determined under the State Contribution 100/90 Formula. A</p> <table border="0"> <thead> <tr> <th data-bbox="591 554 878 583"><u>Years of CalPERS Service</u></th> <th data-bbox="1078 554 1321 583"><u>Applicable Percentage</u></th> </tr> </thead> <tbody> <tr><td data-bbox="721 625 748 655">10</td><td data-bbox="1182 625 1209 655">50</td></tr> <tr><td data-bbox="721 669 748 699">11</td><td data-bbox="1182 669 1209 699">55</td></tr> <tr><td data-bbox="721 714 748 743">12</td><td data-bbox="1182 714 1209 743">60</td></tr> <tr><td data-bbox="721 758 748 787">13</td><td data-bbox="1182 758 1209 787">65</td></tr> <tr><td data-bbox="721 802 748 831">14</td><td data-bbox="1182 802 1209 831">70</td></tr> <tr><td data-bbox="721 846 748 875">15</td><td data-bbox="1182 846 1209 875">75</td></tr> <tr><td data-bbox="721 890 748 919">16</td><td data-bbox="1182 890 1209 919">80</td></tr> <tr><td data-bbox="721 934 748 963">17</td><td data-bbox="1182 934 1209 963">85</td></tr> <tr><td data-bbox="721 978 748 1008">18</td><td data-bbox="1182 978 1209 1008">90</td></tr> <tr><td data-bbox="721 1022 748 1052">19</td><td data-bbox="1182 1022 1209 1052">95</td></tr> <tr><td data-bbox="672 1066 797 1096">20 or more</td><td data-bbox="1182 1066 1209 1096">100</td></tr> </tbody> </table> <p><i>Illustration:</i> In 2019 the State Contribution 100/90 Formula is equal to:</p> <table border="0"> <tbody> <tr> <td data-bbox="656 1205 824 1234">Employee Only</td> <td data-bbox="1159 1205 1214 1234">\$734</td> </tr> <tr> <td data-bbox="602 1268 878 1297">Employee & 1 Dependent</td> <td data-bbox="1149 1268 1224 1297">\$1,398</td> </tr> <tr> <td data-bbox="591 1331 889 1360">Employee & 2+ Dependents</td> <td data-bbox="1149 1331 1224 1360">\$1,788</td> </tr> </tbody> </table> <p>Assume that a Tier II Retiree retired with 15 eligible years of CalPERS service credit, and the retiree is enrolled in Employee & 1 Dependent coverage. In 2019, the retiree's Allowance would be \$1,048.50 (\$1,398 x 0.75).</p>	<u>Years of CalPERS Service</u>	<u>Applicable Percentage</u>	10	50	11	55	12	60	13	65	14	70	15	75	16	80	17	85	18	90	19	95	20 or more	100	Employee Only	\$734	Employee & 1 Dependent	\$1,398	Employee & 2+ Dependents	\$1,788
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Retiree Group	Allowance as of July 1, 2019			
Tier III Retiree	<p>The Allowance is equal to an amount equal to the Applicable Percentage of the contributions determined under the State Contribution 100/90 Formula for Employee Only or Employee & 1 Dependent coverage levels.</p>			
	<p style="text-align: center;"><u>Years of CalPERS Service*</u></p>			
	<p style="text-align: right;"><u>Applicable Percentage</u></p>			
	<p style="text-align: center;">10</p>			
	<p style="text-align: center;">11</p>			
	<p style="text-align: center;">12</p>			
	<p style="text-align: center;">13</p>			
	<p style="text-align: center;">14</p>			
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<p style="text-align: right;">90</p>				
<p style="text-align: right;">95</p>				
<p style="text-align: right;">100</p>				
<p>*No more than 5 years of CalPERS service credit accrued from service with other CalPERS employers may be counted for purposes of determining the Applicable Percentage.</p> <p><i>Illustration:</i> In 2019 the State Contribution 100/90 Formula is equal to:</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 20px;">Employee Only</td> <td style="text-align: right;">\$734</td> </tr> <tr> <td>Employee & 1 Dependent</td> <td style="text-align: right;">\$1,398</td> </tr> </table> <p>Assume that a Tier III Retiree retired with 15 eligible years of CalPERS service credit, and the retiree is enrolled in Employee only coverage. In 2019, the retiree's Allowance would be \$550.50 (\$734x 0.75).</p>	Employee Only	\$734	Employee & 1 Dependent	\$1,398
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