RESOLUTION 02-14

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE RUNNING SPRINGS WATER DISTRICT AMENDING AND RESTATING THE RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN

WHEREAS, on May 21, 2008, the Board of Directors ("Board") approved and adopted the Running Springs Water District Medical Expense Reimbursement Plan ("Plan") for the benefit of District employees which elected not to participate in a District sponsored medical plan; and

WHEREAS, the Plan qualifies as an accident and health plan within the meaning of Section 106 of the Internal Revenue Code so that District contributions to the Plan are excluded from a participating employee's gross income for federal tax purposes; and

WHEREAS, the Plan was subsequently amended on September 17, 2008, August 18, 2010 and July 20, 2011; and

WHEREAS, the Board has been advised that it is necessary to amend and restate the Plan to incorporate these previous amendments and to comply with the Patient Protection and Affordable Care Act's prohibition of annual limits on the dollar value of benefits for participants and preventive service requirements; and

WHEREAS, the Board has reviewed a proposed form of the amended and restated Plan which satisfies the above requirements as prepared by Best Best & Krieger LLP.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Running Springs Water District that:

1. The District hereby adopts the AMENDED AND RESTATED RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN, attached hereto and made a part hereof.

2. The effective date of the AMENDED AND RESTATED RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN shall be February 19, 2014.

ADOPTED this 19th day of February, 2014.

Ayes: 5
Noes: 0
Abstentions: 0
Absent: 0

President, Board of Directors
Running Springs Water District

ATTEST:

Secretary, Board of Directors of the Running Springs Water District

AMENDED AND RESTATED
RUNNING SPRINGS WATER DISTRICT
MEDICAL EXPENSE REIMBURSEMENT PLAN

PLAN SUMMARY

Purpose

The Running Springs Water District established the Running Springs Water District Medical Expense Reimbursement Plan ("Plan") effective July 1, 2008. The Plan was amended on August 18, 2010 and July 20, 2011. The Plan required further amendments in order to comply with the Patient Protection and Affordable Care Act's ("Act") prohibition of annual limits on the dollar value of benefits for participants. Accordingly, the Employer amended and restated the Plan as of February 19, 2014.

The purpose of the Plan is to provide employees that do not participate in a group health insurance plan sponsored by the District, with medical benefits via reimbursement. However, in order to be eligible to participate in the Plan, an employee must be enrolled in a group health plan, such as a plan sponsored by your spouse's employer, that provides minimum value pursuant to Internal Revenue Code ("Code") Section 36B(c)(2)(C)(ii). Participants are eligible to receive reimbursement for his or her "eligible medical expenses" incurred while they are employed with the District and during the period the Plan is in effect. Benefits paid under the Plan are funded entirely by District contributions.

Eligibility and Participation

You are eligible to participate in the Plan if you are a regular employee of the Running Springs Water District who does not participate in a group health insurance plan sponsored by the District but is enrolled in a group health plan that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii), the group health plan in which you are enrolled is not a health reimbursement arrangement, and it meets all applicable requirements of the Act.

As a condition to participate in this Plan, all eligible employees must certify in writing, on a form provided by the District, that the preceding requirements are met.

Benefits

During the course of a Plan Year, at the beginning of each month, each participant will be credited with an amount of Benefit Credits equal to the amount of the contribution the District would have otherwise made on behalf of the employee for medical coverage for that month, as determined by the number of the participant's eligible dependents. These Benefit Credits may be used toward the reimbursement of "eligible medical expenses."

The Plan Year begins on July 1 and ends on June 30 of each year.

Reimbursement Procedure

To receive reimbursement for your "eligible medical expenses", you must complete a claim form

and submit it along with your paid bills to the plan administrator. Claims will be processed for reimbursement on a monthly basis. Upon submission of a claim, you will be reimbursed the full amount of your eligible expenses up to the balance remaining in your reimbursement account. If you have not accumulated a sufficient credit balance in your account in order to receive full reimbursement, you will receive partial reimbursement and the remaining portion of the claim can be automatically considered for reimbursement during the next month of the Plan Year when your account is credited with your next monthly Benefit Credit allotment. However, no claim will be considered for reimbursement using credits from a Plan Year other than the Plan Year during which the expense was incurred.

You will have **90 days** following the end of Plan Year (June 30) to submit claims for reimbursement for amounts incurred during the Plan Year. If you terminate employment, your coverage under the Plan ceases as of your termination date. You will have 90 days following your termination date to submit claims for reimbursement for amounts incurred prior to your termination date.

If you participate in the Plan, you may permanently opt out of and waive future benefits and reimbursements from the Plan at any time. You may also permanently opt out of and waive future benefits and reimbursements from the Plan upon termination of your employment.

Reimbursement Accounts.

You must use all of the funds in your reimbursement account by the end of the Plan Year or you will lose them. The funds must be used for expenses incurred before the end of the Plan Year. The balances cannot be combined or applied toward another benefit plan, carried over into the next year, or converted to cash. The total reimbursements received for any Plan Year may not exceed the total Benefit Credits allocated to your account for any Plan Year. You will receive statements periodically to remind you how much money is left in your reimbursement account.

Eligible Medical Expenses

"Eligible Medical Expense" means any medical expense incurred for you or any of your dependents and for which you could have claimed a medical expense deduction on an itemized federal income tax return. Effective July 1, 2011, you may also submit claims for eligible medical expenses incurred by you on behalf of your adult child (under age 27 years).

Amounts paid for deductibles and co-payments, uninsured medical and dental expenses, costs for prescriptions and over-the-counter-medication, vision care and hearing care and are generally available for reimbursement. Amounts paid for premiums for health plan coverage through your spouse's employer are also eligible for reimbursement; however, if the premiums are paid by your spouse on a "pre-tax" basis, your reimbursement will be included in your taxable compensation.

Effective January 1, 2014, and in accordance with the Act, the Plan will no longer reimburse amounts paid for premiums of individual health plan coverage.

Effective July 1, 2011, you will no longer be reimbursed for non-prescribed over-the-counter medicines unless you provide a copy of your doctor's prescription or the expense is for insulin.

Most expenses must be "medically necessary" and/or prescribed by a licensed physician to qualify. Covered expenses do not include expenses for non-reconstructive cosmetic surgery nor do they include expenses for personal mileage to go to the doctor.

Eligible expenses must have been incurred during your period of participation in the Plan. Therefore, you cannot be reimbursed for any expenses incurred before the Plan became effective or prior to the date you became covered under the Plan, if later. If you terminate employment with the District for any reason, expenses incurred after your termination date will not be reimbursed unless you elect COBRA continuation coverage.

Claims Procedures

All claims for benefits under the Plan are processed by the Plan Administrator. To obtain reimbursement under the Plan, you must file a written claim for benefits with the Plan Administrator. The Plan Administrator will supply you with the appropriate claim form.

The District or its designated representative has final authority to determine the amount of benefits that will be paid on any claim. In making benefit determinations, the District has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim.

If your claim is denied, may request a review of the denial within 60 days of receipt of the denial notice. Your request for a review must be in writing.

The District must issue a review decision on your appeal not later than 60 days after receiving your request for a review. Under special circumstances an extension of time may be needed. If an extension is needed, the District must inform you of the extension and must make a decision within 120 days from the receipt of your review request.

Future of the Plan

The Plan is based on the District's understanding of the current provisions of the Internal Revenue Code. The District reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the District. The District's rights with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by any provision of the Plan.

This Plan Summary describes the basic provisions of the Plan. Your specific rights to benefits under the Plan are governed by the Plan document and the individual component plans. If you have any questions after reading this Summary, please contact the Plan Administrator.

AMENDED AND RESTATED
RUNNING SPRINGS WATER DISTRICT
MEDICAL EXPENSE REIMBURSEMENT PLAN

RECITALS

A. RUNNING SPRINGS WATER DISTRICT adopted the RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN on May 21, 2008, and subsequently amended the Plan on September 17, 2008, August 18, 2010 and July 20, 2011.

B. It is necessary for the Employer to amend the Plan in order to comply with the Patient Protection and Affordable Care Act's prohibition of annual limits on the dollar value of benefits for participants.

C. Accordingly, the Employer hereby amends and restates, and adopts the AMENDED AND RESTATED RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN effective February 19, 2014.

ARTICLE I
TITLE AND PURPOSE

The Plan is intended as an uninsured health reimbursement arrangement for employees not participating in an Employer sponsored primary medical plan, to provide reimbursement of Employee out-of-pocket expenses for certain medical benefit premium payments, medical hospitalization and expenses that exceed the deductible or co-payment limits of any insurance policies covering such costs or which are otherwise not covered by insurance. The Employer intends that the Plan qualify as an accident and health plan within the meaning of Section 106 of the Internal Revenue Code ("Code") so that the Employer's contributions on behalf of participating Employees will be excludable from gross income for federal income tax purposes and Section 105 of the Code so that the benefits provided under the Plan are eligible for exclusion from the Participant's income.

ARTICLE II
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

2.1 Benefit Credits. "Benefit Credits" means that amount of Employer Allowance allocated to a Participant's reimbursement account under this Plan pursuant to Section 6.1 herein.

2.2 Benefits. "Benefits" means any amounts paid to a Participant in the Plan as reimbursement for Eligible Medical Expenses.

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

2.4 Dependent. "Dependent" includes the spouse or dependent of a Participant as defined under Internal Revenue Code Section 152, determined without regard to Code Section 152(b)(1), (b)(2) or (d)(1)(B), and any child of the Participant (as defined in Code Section 152(f)(1)) who as of the end of the taxable year has not attained age 27 years.

2.5 Effective Date. "Effective Date" shall mean July 1, 2008, the date this Plan first became effective.

2.6 Eligible Medical Expenses. "Eligible Medical Expenses" means those expenses incurred by the Participant, or the Participant's Dependents, after the Participant's entry date. Such expenses shall include amounts paid for audio, dental, optical and medical services, purchase of prescription drugs and over-the-counter medicines, medical deductibles and, except as provided herein, premiums for accident or health insurance (including hospitalization, surgical, and medical insurance), and such other expenses as are covered by Section 213(d) of the Code, as it may be amended from time to time, which are not covered by any insurance plan of which the Participant, the Participant's Spouse or Dependents are beneficiaries, whether or not such insurance is paid for by the Employer. Premiums for individual market coverage are not eligible for reimbursement under the Plan. Amounts paid for premiums for coverage under medical plans maintained by the District other than its primary medical plan shall not be eligible for reimbursement under the Plan.

Such Eligible Expenses shall not include an expense incurred for an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty for Uniformed Service. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

Notwithstanding the above, with respect to expenses incurred on or after July 1, 2011, the definition of Eligible Medical Expenses shall include expenses incurred for medicines or drugs only if (1) the medicine or drug requires a prescription, (2) is available without a prescription and the individual obtains a prescription, or (3) is insulin.

2.7 Employee. "Employee" means an employee of the Employer who has satisfied the conditions for eligibility to participate in the Plan and, to the extent necessary, a retired or terminated employee who is entitled to benefits under the Plan.

2.8 Employer. "Employer" means the RUNNING SPRINGS WATER DISTRICT, and any other organization which adopts this Plan with the consent of Employer, and any successor of such Employer electing to continue this Plan.

2.9 Employer Allowance. "Employer Allowance" means the amount of the monthly contribution made by the Employer on behalf of each Participant under the Plan.

2.10 Participant. "Participant" means any Employee who has met the conditions for participation in the Plan set forth in Section 4.1.

2.11 Plan. "Plan" means the RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN, described herein.

2.12 Plan Administrator. "Plan Administrator" or "Administrator" means the Employer. The Plan Administrator shall be responsible for the administration of the Plan, including the delegation of various Plan responsibilities and duties.

2.13 Plan Year. "Plan Year" means each twelve-month period commencing each July 1 and ending on June 30.

2.14 Uniformed Service. "Uniformed Service" 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 State in time of war or emergency.

ARTICLE III
INTEGRATION WITH GROUP HEALTH PLAN

This Plan is intended to comply with the Affordable Care Act's prohibition on annual and lifetime limits and preventive services requirements. Accordingly, it shall only remain in effect as long as Employer offers a group health plan other than this Plan to each regular, full-time employee that provides "minimum value" as defined in Code Section 36B(c)(2)(C)(ii).

ARTICLE IV
ELIGIBILITY AND PARTICIPATION

4.1 Commencement of Participation. Each employee that elects not to participate in the primary group medical plan sponsored by the Employer shall become immediately eligible to participate in the Plan if he or she is enrolled in a group health plan that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii), the group health plan in which he or she is enrolled is not a health reimbursement arrangement, and it meets all applicable requirements of the Patient Protection and Affordable Care Act. Each Employee must annually, prior to the commencement of each Plan Year, certify in writing to that he or

she is enrolled in such group health plan, and that he or she will immediately notify the Employer if he or she becomes dis-enrolled in such group health plan for any reason.

4.2 Cessation of Participation. A Participant will cease to participate upon the earlier of his termination of employment, his election to participate in the primary group health insurance plan sponsored by the Employer, or if he is no longer enrolled in group health plan coverage sponsored by someone other than the Employer that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii). The coverage of a Participant may also be terminated if such Employee is absent for more than thirty-one (31) days for a period of duty in Uniformed Service. Nothing in this Section 4.2 shall prohibit the payment of Benefits with respect to claims received after the Participant's termination of participation provided the claim relates to the reimbursement of Eligible Medical Expenses incurred during the period of participation.

4.3 Recommencement of Participation. A former active Participant will recommence participation as of his date of reemployment provided that the requirements of Section 4.1 are satisfied.

4.4 Uniformed Service Under USERRA & The Veterans Benefits Improvements Act of 2004. A Participant whose coverage under the Plan is terminated on account of his being in Uniformed Service, and is later reinstated, shall not be subject to a new waiting period or eligibility requirement, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the Uniformed Service and Employee returns to active employment within ninety (90) days of completing a period of duty.

ARTICLE V
AVAILABLE BENEFITS

5.1 Provision of Benefits. Benefits under this Plan shall take the form of reimbursement by the Employer for Eligible Medical Expenses incurred by a Participant during a period of participation subject to the provisions of this Plan. However, reimbursement for Eligible Medical Expenses incurred during a period of participation may be made after such participation ceases subject to the timing requirements for submitting a reimbursement request as specified in Section 8.3. Reimbursement shall not be made for any amount that does not qualify as an Eligible Medical Expense, and no Participant or former Participant shall receive any reimbursement which exceeds the amount actually incurred for the expense.

5.2 Claims for Benefits. No benefit shall be paid under the Plan unless a Participant has first submitted a written claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator.

5.3 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of "highly compensated individuals" (as defined under Section 105(h) of the Code) as to eligibility to participate, contributions and benefits, and to comply in this respect with the

requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such highly compensated individuals who are Participants, and/or reduce contributions under the Plan made on behalf of highly compensated individuals who are Participants, to the extent necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

5.4 Taxation of Benefits. Reimbursement for premiums paid for coverage under another employer's group health plan shall be reported as taxable income to the employee being reimbursed.

ARTICLE VI
EMPLOYER CONTRIBUTIONS AND FUNDING

6.1 Funding. The Benefit provided herein shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts contributed by the Employer on a monthly basis in the form of an Employer Allowance. The amount of the Employer Allowance to be contributed each month shall be equal to the amount of the contribution the Employer would have otherwise made on behalf of the Employee for medical coverage for that month, as determined by the number of the Employee's eligible Dependents.

6.2 Participant Accounts. No money shall actually be allocated to any account(s) on behalf of Participants but shall be credited to a separate ledger account in the Participant's name. Such amounts or Benefit Credits credited to a Participant's account for any month shall be used only toward the payment of or reimbursement for Participant's Eligible Expenses, and only if the Participant applies for reimbursement.

6.3 Amount of Reimbursement. A Participant shall be entitled to benefits under this Plan in an amount that does not exceed his Benefit Credits. Each payment hereunder shall be a charge to the Participant's Benefit Credits. No Participants shall be permitted to maintain a negative account balance.

6.4 Forfeiture of Unused Benefits. In the event that, at the end of the Plan Year and the time period provided for in Section 8.3, a Participant's account contains Benefit Credits which are unused during such period, any such remaining amount shall be forfeited by the Participant and the account balance reduced to zero. A Participant shall receive no refund of amounts which are not incurred and substantiated during a Plan Year and for which a claim for reimbursement is not submitted within the time period provided for in Section 8.3, for any reason.

6.5 Waiver of Future Benefits. Each employee who participates in this Plan is permitted to permanently opt out of and waive future Benefits and reimbursements from the Plan at any time. Further, upon termination of employment, the Employee is allowed to permanently opt out of and waive future Benefits and reimbursements from the Plan.

ARTICLE VII
ADMINISTRATION

7.1 Administrator. The Employer shall be the Plan Administrator of the Plan; however, the Employer reserves the right to appoint any person or entity, including an employee of the Employer, to administer the Plan on its behalf.

7.2 Fiduciary. The Employer shall be the fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer's responsibility to an employee of Employer, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

7.3 Rules of Administration. The Employer may adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

7.4 Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical, claims administration and other services to carry out the Plan. The costs of such services and other administrative expenses shall be paid by the Employer.

7.5 Funding Policy. The Employer may periodically, at its discretion, review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

7.6 Claims Procedure.

(a) To receive benefits under the Plan, a Participant must submit a written claim for benefits to the Plan Administrator.

The Plan Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan or has not been advised of his Benefits, he may submit a written request to the Plan Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Plan Administrator must respond to such a request within a reasonable time.

Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating in a format determined to be understood by the claimant:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions on which the denial is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim; and

(4) an explanation of the claim review procedure set forth in Paragraph (b) below.

(b) Within sixty (60) days of receipt by a claimant of a notice denying a claim under Paragraph (a), the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator or by the Administrator which may be appointed by the Employer for that purpose. The Plan Administrator may extend the sixty (60) day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Plan Administrator or Administrator shall make a decision promptly, and not later than 60 days after the Plan Administrator's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the Administrator deems one necessary) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

7.7 Nondiscriminatory Operation. All rules, decisions and designations by the Employer and each administrative committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

7.8 Liability of Administrative Personnel. Neither the Employer, nor any of its employees, nor any provider of services under Section 7.4 herein, shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility, if one is owed, with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

7.9 Use of Electronic Medium for Participant Notices.

a. Definition of Electronic Medium. "Electronic Medium" means an electronic method of communication between the Plan Administrator (or its designated representative) and Employee thereby allowing each party to send and receive notices 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 than is readily understandable. The electronic medium shall be designed to preclude any person, other than the appropriate individual, from making a Participant election 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 Plan 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 related 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 Plan 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 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 Plan 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.

ARTICLE VIII
PAYMENT OF BENEFITS

8.1 Claims for Benefits. No benefit shall be paid under the Plan unless a Participant has first submitted a written claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in Section 8.2.

8.2 Reimbursement of Eligible Medical Expenses. Each Participant who desires to receive reimbursement under the Plan for Eligible Medical Expenses shall submit to

the Plan Administrator, at the times indicated in Section 8.3, on a form provided by the Employer, or responses to other supplementary factual requests, containing the following information:

(a) the name of the person or persons on whose behalf Eligible Medical Expenses have been incurred;

(b) the nature of the expenses so incurred;

(c) the date of the expenses so incurred;

(d) the amount of the requested reimbursement; and

(e) that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

As soon as is administratively feasible at the beginning of each month during the Plan Year, the Plan Administrator or his designated claims administration representative shall review all the claim forms submitted by Participants during the prior month in accordance with the foregoing procedures and shall pay each Participant the Benefit Credits which each Participant is entitled to receive under the Plan.

8.3 Time Limit. No expense shall be reimbursed for any Plan Year unless the Participant submits a claim for such reimbursement within ninety (90) days after the end of such Plan Year or ninety (90) days following a Participant's date of termination of participation.

8.4 Source of Benefit Payments. The sole source for payment of benefits under this Plan shall be the unfunded accounts established for each Participant pursuant to Article VI. The Plan Administrator shall pay to each Participant the benefits which he is entitled to receive under this Plan, and his reimbursement account under the Plan shall be debited accordingly. A Participant shall not be entitled to receive reimbursement for any Eligible Expenses or any portion thereof which exceeds the Participant's total Benefit Credits for a Plan Year.

ARTICLE IX
CONTINUATION OF COVERAGE

9.1 In General. During any Plan Year during which the Employer has 20 or more Employees, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan pursuant to the continuation coverage provisions of the Public Health Service Act, as set forth in 42 U.S.C. §300bb et seq., and any amendments thereto.

9.2 Definitions. For purposes of this Article IX, 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 herein and those of Article II, the defined terms set forth herein shall control:

(a) "Dependent" means an individual who meets the definition of dependent under this Plan.

(b) "Election period" means the sixty (60) day period following the Qualifying Event during which a Qualified Beneficiary may elect continuation coverage. This sixty (60) day period begins not later than the date of termination of coverage 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" means an individual who, on the day before the Qualifying Event, is covered under this Plan as the covered Employee, the spouse of the covered Employee or dependent child of the covered Employee, and loses coverage under the Plan as a result of the Qualifying Event. Qualified Beneficiary shall also 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.

(d) "Qualifying Event" means with respect to a covered Employee, any of the following events which results in the loss of coverage of 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); (5) a dependent child who ceases to be a Dependent under the terms of this Plan; or (6) the Employer's filing for Chapter 11 reorganization as it would affect retiree coverage.

9.3 Continuation Coverage. To the extent required by Section 9.1 above, a Qualified Beneficiary is entitled to elect continuation coverage pursuant to the timing requirements of this Article IX. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required. Unless otherwise specified in the 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 on behalf of any Qualified Beneficiaries who are Dependents of the Employee or spouse.

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.

9.4 Limitations on Continuation Coverage; Length of Coverage.

(a) Unavailability Of Continuation Coverage. Continuation coverage under this Plan shall not be offered if the Participant's remaining Benefit Credits in his spending account is zero on the date of the Qualifying Event.

(b) Limited Continuation Coverage. If a Participant is showing a remaining balance of Benefit Credits in his spending account as of the date of the Qualifying Event, the Employer shall offer continuation coverage under the Plan for the remainder of the Plan Year for the year in which the Qualifying Event occurred.

9.5 Notification Requirements.

(a) Notification by Qualified Beneficiary. Within sixty (60) days, each Qualified Beneficiary must notify the Employer of the occurrence of either the divorce or legal separation of the Employee or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan.

(b) Notification to Qualified Beneficiary.

(1) Upon commencement of participating in the Plan, the Administrator shall provide written notice to each covered Employee and his Spouse of the right to continuation coverage under the Plan.

(2) Within fourteen (14) days of receiving notice of the occurrence of a Qualifying Event, the Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under the Plan. Notification 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.

9.6 Termination of Continuation Coverage. The continuation coverage provided hereunder shall be terminated prior to the last day of the Plan Year in which the Qualified Beneficiary experiences the Qualifying Event if the Qualified Beneficiary fails to make timely payment of the required contribution.

9.7 Contribution. The monthly cost or the premium for coverage hereunder shall be calculated as follows: "the total amount of the monthly Employer Allowance." 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. A Qualified Beneficiary may elect to pay such premium in monthly installments. Notwithstanding, for an election made during the Election Period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election provided payment is made within forty-five (45) days of the date of the election.

ARTICLE X
MISCELLANEOUS

10.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by action of the Employer. The Employer may amend or modify this Plan retroactively to enable the Plan to provide non-taxable medical expense reimbursement benefits under Section 105 of the Code. No amendment shall deprive any Participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

10.2 Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment or reemployment between the Employer and any Participant or to be a consideration or an inducement for the reemployment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer.

10.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

10.4 Payments to Beneficiary. Any benefits otherwise payable to a Participant or his or her Dependents following the date of death of such Participant or his or her Dependents relating to a claim arising before his or her death shall be paid to his or her spouse, or, if there is no surviving spouse, to the Participant's or Dependent's estate.

10.5 Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Employer.

10.6 Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require (either directly to the Employer or to any person delegated by it).

10.7 Status of Benefits. The Employer believes that this Plan is written in accordance with Section 105 of the Code and that it provides certain benefits to Employees 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.

10.8 Applicable Law. The Plan shall be construed and enforced according to the laws of the State of California to the extent not pre-empted by any federal law.

10.9 Lost Distributees. Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit.

10.10 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

10.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

10.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

10.13 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.14 Source of Payments. The Employer shall be the sole source of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer 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 Employee or beneficiary.

ARTICLE XI
HIPAA PRIVACY STANDARDS

11.1 Employer's Certification of Compliance. The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 C.F.R. § 164.504(f)(2)(ii), and that Employer agrees to conditions of disclosure set forth in this Article XI.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer or the Administrator information on whether the individual is participating in the Plan.

11.3 Permitted Uses and Disclosures of Summary Health Information. The Plan may disclose Summary Health Information to the Employer or the Administrator, provided that the Employer or the Administrator requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information that (1) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 C.F.R. § 164.5 14(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.51 4(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

11.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article XI (including, but not limited to the restrictions on Employer's use and disclosure described in 10.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

11.5 Restrictions on Employer's Use and Disclosure of Protected Health Information.

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to Protected Health Information.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(e) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

11.6 Adequate Separation Between Employer and the Plan.

(a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information received from the Plan or a business associate servicing the Plan: Privacy Official, employees in the Employer's Human Resources Department; and any other class of employees designated in writing by the Privacy Official.

(b) The employees, classes of employees or other workforce members identified in Section 11.6(a), above, will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 11.5(a), above.

(c) The employees, classes of employees or other workforce members identified in Section 11.6(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information in breach or violation of or noncompliance with the provisions of this Article XI.

IN WITNESS WHEREOF, the Employer has caused this Medical Expense Reimbursement Plan to be executed on February 19, 2014.

EMPLOYER:

RUNNING SPRINGS WATER DISTRICT

By: _____
Name: RYAN GROSS
Title: GENERAL MANAGER

APPROVED AS TO FORM AND CONTENT:

BEST BEST & KRIEGER LLP

By: _____
Attorneys for Employer

AMENDED AND RESTATED
RUNNING SPRINGS WATER DISTRICT
MEDICAL EXPENSE REIMBURSEMENT PLAN

ANNUAL EMPLOYEE ATTESTATION FORM

I, _____, am an employee of Running Springs Water District ("District"). I have elected not to participate in the primary group medical plan sponsored by the District. I attest that I am presently enrolled in a group health plan that provides minimum value pursuant to Internal Revenue Code Section 36B(c)(2)(C)(ii). Further, I attest that the group health plan in which I am enrolled is not a health reimbursement arrangement and that it complies with applicable requirements of the Patient Protection and Affordable Care Act.

I understand that my ability to participate in the Amended and Restated Running Springs Water District Medical Expense Reimbursement Plan is conditioned on my continued enrollment in the group health plan described in the above paragraph. In the event that I become dis-enrolled in such plan for any reason, I will immediately notify the District.

Dated: _____

_____
Signature

ATTACHMENT 2

AMENDED AND RESTATED
RUNNING SPRINGS WATER DISTRICT
MEDICAL EXPENSE REIMBURSEMENT PLAN

PLAN SUMMARY

Purpose

The Running Springs Water District established the Running Springs Water District Medical Expense Reimbursement Plan ("Plan") effective July 1, 2008. The Plan was amended on August 18, 2010 and July 20, 2011. The Plan required further amendments in order to comply with the Patient Protection and Affordable Care Act's ("Act") prohibition of annual limits on the dollar value of benefits for participants. Accordingly, the Employer amended and restated the Plan as of January ___, 2014.

The purpose of the Plan is to provide employees, that do not participate in a group health insurance plan sponsored by the District, with medical benefits via reimbursement. ~~Each participant is~~However, in order to be eligible to participate in the Plan, an employee must be enrolled in a group health plan, such as a plan sponsored by your spouse's employer, that provides minimum value pursuant to Internal Revenue Code ("Code") Section 36B(c)(2)(C)(ii). Participants are eligible to receive reimbursement for his or her "eligible medical expenses" incurred while they are employed with the District and during the period the Plan is in effect. Benefits paid under ~~this~~the Plan are funded entirely by District contributions.

Eligibility and Participation

You are eligible to participate in the Plan if you are a regular employee of the Running Springs Water District ~~and~~who does not ~~participating~~participate in a group health insurance plan sponsored by the District~~.~~ but is enrolled in a group health plan that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii), the group health plan in which you are enrolled is not a health reimbursement arrangement, and it meets all applicable requirements of the Act.

As a condition to participate in this Plan, all eligible employees must certify in writing, on a form provided by the District, that the preceding requirements are met.

Benefits

During the course of a Plan Year, at the beginning of each month, each participant will be credited with an amount of Benefit Credits equal to the amount of the contribution the District would have otherwise made on behalf of the employee for medical coverage for that month, as determined by the number of the ~~Employee's~~participant's eligible dependents. These Benefit Credits may be used toward the reimbursement of "eligible medical expenses."

The Plan Year begins on July 1 and ends on June 30 of each year.

Reimbursement Procedure

To receive reimbursement for your "eligible medical expenses", you must complete a claim form and submit it along with your paid bills to the plan administrator. ~~Once the plan administrator receives the claims all~~ Claims will be processed for reimbursement on a monthly basis. Upon submission of a claim, you will be reimbursed the full amount of your eligible expenses up to the balance remaining in your ~~spending~~reimbursement account. If you have not accumulated a sufficient credit balance in your account in order to receive full reimbursement, you will receive partial reimbursement and the remaining portion of the claim can be automatically considered for reimbursement during the next month of the Plan Year when your account is credited with your next monthly Benefit Credit allotment. However, no claim will be considered for reimbursement using credits from a Plan Year other than the Plan Year during which the expense was incurred.

You will have **90 days** following the end of Plan Year (June 30) to submit claims for reimbursement for amounts incurred during the Plan Year. If you terminate employment, your coverage under the Plan ceases as of your termination date. You will have 90 days following your termination date to submit claims for reimbursement for amounts incurred prior to your termination date.

If you participate in the Plan, you may permanently opt out of and waive future benefits and reimbursements from the Plan at any time. You may also permanently opt out of and waive future benefits and reimbursements from the Plan upon termination of your employment.

Reimbursement Accounts.

You must use all of the funds in your ~~medical spending~~reimbursement account by the end of the Plan Year or you will lose them. The funds must be used for expenses incurred before the end of the Plan Year. The balances cannot be combined or applied toward another benefit plan, carried over into the next year, or converted to cash. The total reimbursements received for any Plan Year may not exceed the total Benefit Credits allocated to your account for any Plan Year. You will receive statements periodically to remind you how much money is left in your ~~spending~~reimbursement account.

Eligible Medical Expenses

"Eligible Medical Expense" means any medical expense incurred for you or any of your dependents and for which you could have claimed a medical expense deduction on an itemized federal income tax return. Effective July 1, 2011, you may also submit claims for eligible medical expenses incurred by you on behalf of your adult child (under age 27 years).

Amounts paid for ~~premiums of individual health plan coverage,~~ deductibles and co-payments, uninsured medical and dental expenses, costs for prescriptions and over-the-counter-medication, vision care and hearing care and are generally available for reimbursement. Amounts paid for premiums for health plan coverage through your spouse's employer are also eligible for reimbursement; however, if the premiums are paid by your spouse on a "pre-tax" basis, your reimbursement will be included in your taxable compensation.

Effective January 1, 2014, and in accordance with the Act, the Plan will no longer reimburse

amounts paid for premiums of individual health plan coverage.

Effective July 1, 2011, you will no longer be reimbursed for non-prescribed over-the-counter medicines unless you provide a copy of your doctor's prescription or the expense is for insulin.

Most expenses must be "medically necessary" and/or prescribed by a licensed physician to qualify. Covered expenses do not include expenses for non-reconstructive cosmetic surgery nor do they include expenses for personal mileage to go to the doctor.

Eligible expenses must have been incurred during your period of participation in the Plan. Therefore, you cannot be reimbursed for any expenses incurred before the Plan became effective or prior to the date you became covered under the Plan, if later. If you terminate employment with the District for any reason, expenses incurred after your termination date will not be reimbursed unless you elect COBRA continuation coverage.

Claims Procedures

All claims for benefits under the Plan are processed by the Plan Administrator. To obtain reimbursement under the Plan, you must file a written claim for benefits with the Plan Administrator. The Plan Administrator will supply you with the appropriate claim form.

The District or its designated representative has final authority to determine the amount of benefits that will be paid on any claim. In making benefit determinations, the District has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim.

If your claim is denied, may request a review of the denial within 60 days of receipt of the denial notice. Your request for a review must be in writing.

~~You will be notified within 30 days if your claim is denied, the District will give the reasons for the denial of the claim; however, if special circumstances require an extension of time for processing the claim (up to 15 days if the extension is required due to matters beyond the District's control), the District will provide you with written notice of the extension within the initial 30 day period. You will have at least 45 days to provide any additional information requested by the District (if the need for the extension is due to the District's need for additional information from you or your health care providers). If your claim is denied, you have at least 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing.~~

~~In connection with your right to appeal the District's initial determination regarding your claim, you also (1) may review pertinent documents and submit issues and comments in writing; (2) will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim; (3) will, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; (4) be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial claim determination; and (5) are entitled to have your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical~~

~~judgment; this individual may not have participated in the initial denial.~~

The District must issue a review decision on your appeal not later than 60 days after receiving your request for a review. Under special circumstances an extension of time may be needed. If an extension is needed, the District must inform you of the extension and must make a decision within 120 days from the receipt of your review request.

Future of the Plan

The Plan is based on the District's understanding of the current provisions of the Internal Revenue Code. The District reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and the District. The District's rights with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by any provision of the Plan.

This ~~Summary~~ Plan ~~Description~~Summary describes the basic provisions of the Plan. Your specific rights to benefits under the Plan are governed by the Plan document and the individual component plans. If you have any questions after reading this Summary, please contact the Plan Administrator.

AMENDED AND RESTATED
RUNNING SPRINGS WATER DISTRICT
MEDICAL EXPENSE REIMBURSEMENT PLAN

RECITALS

A. RUNNING SPRINGS WATER DISTRICT adopted the RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN on May 21, 2008, and subsequently amended the Plan on September 17, 2008, August 18, 2010 and July 20, 2011.

B. It is necessary for the Employer to amend the Plan in order to comply with the Patient Protection and Affordable Care Act's prohibition of annual limits on the dollar value of benefits for participants.

C. Accordingly, the Employer hereby ~~establishes the~~amends and restates, and adopts the AMENDED AND RESTATED RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN ~~as of July 1, 2008, on the following terms and conditions~~effective January ____, 2014.

ARTICLE I
TITLE AND PURPOSE

The Plan is intended as an uninsured health reimbursement arrangement for employees not participating in an Employer sponsored primary medical plan, to provide reimbursement of Employee out-of-pocket expenses for certain medical benefit premium payments, medical hospitalization and expenses that exceed the deductible or co-payment limits of any insurance policies covering such costs or which are otherwise not covered by insurance. The Employer intends that the Plan qualify as an accident and health plan within the meaning of Section 106 of the Internal Revenue Code (~~the~~ "Code") so that the Employer's contributions on behalf of participating Employees will be excludable from gross income for federal income tax purposes and Section 105 of the Code so that the benefits provided under the Plan are eligible for exclusion from the Participant's income.

ARTICLE II
DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

2.1 Benefit Credits. "Benefit Credits" means that amount of Employer Allowance allocated to a Participant's reimbursement account under this Plan pursuant to Section ~~5.1~~6.1 herein.

2.2 Benefits. "Benefits" means any amounts paid to a Participant in the Plan as reimbursement for Eligible Medical Expenses.

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

2.4 Dependent. "Dependent" ~~means an individual who is~~includes the spouse or ~~legal~~ dependent of a Participant as defined ~~in~~under Internal Revenue Code Section 152~~ of the Code~~, determined without regard to Code Section 152(b)(1), (b)(2) ~~and~~or (d)(1)(B) ~~of~~, and any child of the Participant (as defined in Code Section 152(f)(1)) who as of the end of the taxable year has not attained age 27 years.

2.5 Effective Date. "Effective Date" shall mean July 1, 2008, the date this Plan first became effective.

2.6 Eligible Medical Expenses. "Eligible Medical Expenses" means those expenses incurred by the Participant, or the Participant's Dependents, after the Participant's entry date. Such expenses shall include amounts paid for audio, dental, optical and medical services, purchase of prescription drugs and over-the-counter medicines, medical deductibles and, except as provided herein, premiums for accident or health insurance (including hospitalization, surgical, and medical insurance), and such other expenses as are covered by Section 213(d) of the Code, as it may be amended from time to time, which are not covered by any insurance plan of which the Participant, the Participant's Spouse or Dependents are beneficiaries, whether or not such insurance is paid for by the Employer. Premiums for individual market coverage are not eligible for reimbursement under the Plan. Amounts paid for premiums for coverage under medical plans maintained by the District other than its primary medical plan shall not be eligible for reimbursement under the Plan.

Such Eligible Expenses shall not include an expense incurred for an illness or injury (or aggravation of an illness or injury) incurred by an Employee during a period of duty for Uniformed Service. For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

Notwithstanding the above, with respect to expenses incurred on or after July 1, 2011, the definition of Eligible Medical Expenses shall include expenses incurred for medicines or drugs only if (1) the medicine or drug requires a prescription, (2) is available without a prescription and the individual obtains a prescription, or (3) is insulin.

2.7 Employee. "Employee" means an employee of the Employer who has satisfied the conditions for eligibility to participate in the Plan and, to the extent necessary, a retired or terminated employee who is entitled to benefits under the Plan.

2.8 Employer. "Employer" means the RUNNING SPRINGS WATER DISTRICT, and any other organization which adopts this Plan with the consent of Employer, and any successor of such Employer electing to continue this Plan.

2.9 Employer Allowance. "Employer Allowance" means the amount of the monthly contribution made by the Employer on behalf of each Participant under the Plan.

2.10 Participant. "Participant" means any Employee who has met the conditions for participation in the Plan set forth in Section 4.1.

2.11 Plan. "Plan" means the RUNNING SPRINGS WATER DISTRICT MEDICAL EXPENSE REIMBURSEMENT PLAN, described herein.

2.12 Plan Administrator. "Plan Administrator" or "Administrator" means the Employer. The Plan Administrator shall be responsible for the administration of the Plan, including the delegation of various Plan responsibilities and duties.

2.13 Plan Year. "Plan Year" means each twelve-month period commencing each July 1 and ending on June 30.

2.14 Uniformed Service. "Uniformed Service" 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 State in time of war or emergency.

ARTICLE III
INTEGRATION WITH GROUP HEALTH PLAN

This Plan is intended to comply with the Affordable Care Act's prohibition on annual and lifetime limits and preventive services requirements. Accordingly, it shall only remain in effect as long as Employer offers a group health plan other than this Plan to each regular, full-time employee that provides "minimum value" as defined in Code Section 36B(c)(2)(C)(ii).

~~ARTICLE III~~ARTICLE IV
ELIGIBILITY AND PARTICIPATION

~~3.1~~4.1 ~~3.1~~ Commencement of Participation. Each employee that elects not to participate in the primary group medical plan sponsored by the Employer shall become immediately eligible to participate in the Plan~~.~~ if he or she is enrolled in a group health plan that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii), the group health plan in which he or she is enrolled is not a health reimbursement arrangement, and it meets all applicable requirements of the Patient Protection and Affordable Care Act. Each Employee must annually, prior to the commencement of each Plan Year, certify in writing to that he or

she is enrolled in such group health plan, and that he or she will immediately notify the Employer if he or she becomes dis-enrolled in such group health plan for any reason.

~~3.2~~4.2 ~~3.2~~ Cessation of Participation. A Participant will cease to participate upon the earlier of his termination of employment ~~or~~, his election to participate in the primary group health insurance plan sponsored by the Employer, or if he is no longer enrolled in group health plan coverage sponsored by someone other than the Employer that provides minimum value pursuant to Code Section 36B(c)(2)(C)(ii). The coverage of a Participant may also be terminated if such Employee is absent for more than thirty-one (31) days for a period of duty in Uniformed Service. Nothing in this Section ~~3.2~~4.2 shall prohibit the payment of Benefits with respect to claims received after the Participant's termination of participation provided the claim relates to the reimbursement of Eligible Medical Expenses incurred during the period of participation.

~~3.3~~4.3 ~~3.3~~ Recommencement of Participation. A former active Participant will recommence participation as of his date of reemployment provided that the requirements of Section 4.1 are satisfied.

~~3.4~~4.4 ~~3.4~~ Uniformed Service Under USERRA & The Veterans Benefits Improvements Act of 2004. A Participant whose coverage under the Plan is terminated on account of his being in Uniformed Service, and is later reinstated, shall not be subject to a new waiting period or eligibility requirement, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the Uniformed Service and Employee returns to active employment within ninety (90) days of completing a period of duty.

~~ARTICLE IV~~ARTICLE V~~ARTICLE IV~~
AVAILABLE BENEFITS

~~4.1~~5.1 ~~4.1~~ Provision of Benefits. Benefits under this Plan shall take the form of reimbursement by the Employer for Eligible Medical Expenses incurred by a Participant during a period of participation subject to the provisions of this Plan. However, reimbursement for Eligible Medical Expenses incurred during a period of participation may be made after such participation ceases subject to the timing requirements for submitting a reimbursement request as specified in Section ~~7.3~~8.3. Reimbursement shall not be made for any amount that does not qualify as an Eligible Medical Expense, and no Participant or former Participant shall receive any reimbursement which exceeds the amount actually incurred for the expense.

~~4.2~~5.2 ~~4.2~~ Claims for Benefits. No benefit shall be paid under the Plan unless a Participant has first submitted a written claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator.

~~4.3~~5.3 ~~4.3~~ Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of "highly compensated individuals" (as defined under Section 105(h) of the Code) as to eligibility to participate, contributions and benefits, and to comply in this

respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such highly compensated individuals who are Participants, and/or reduce contributions under the Plan made on behalf of highly compensated individuals who are Participants, to the extent necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

~~4.4~~5.4 ~~4.4~~ Taxation of Benefits. Reimbursement for premiums paid for coverage under another employer's group health plan shall be reported as taxable income to the employee being reimbursed.

~~ARTICLE V~~ARTICLE VI~~ARTICLE V~~
EMPLOYER CONTRIBUTIONS AND FUNDING

~~5.1~~6.1 ~~5.1~~ Funding. The Benefit provided herein shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts contributed by the Employer on a monthly basis in the form of an Employer Allowance. The amount of the Employer Allowance to be contributed each month shall be equal to the amount of the contribution the Employer would have otherwise made on behalf of the Employee for medical coverage for that month, as determined by the number of the Employee's eligible Dependents.

~~5.2~~6.2 ~~5.2~~ Participant Accounts. No money shall actually be allocated to any account(s) on behalf of Participants but shall be credited to a separate ledger account in the Participant's name. Such amounts or Benefit Credits credited to a Participant's account for any month shall be used only toward the payment of or reimbursement for Participant's Eligible Expenses, and only if the Participant applies for reimbursement.

~~5.3~~6.3 ~~5.3~~ Amount of Reimbursement. A Participant shall be entitled to benefits under this Plan in an amount that does not exceed his Benefit Credits. Each payment hereunder shall be a charge to the Participant's Benefit Credits. No Participants shall be permitted to maintain a negative account balance.

~~5.4~~6.4 ~~5.4~~ Forfeiture of Unused Benefits. In the event that, at the end of the Plan Year and the time period provided for in Section 8.3, a Participant's account contains Benefit Credits which are unused during ~~a Plan Year~~such period, any such remaining amount shall be forfeited by the Participant and the account balance reduced to zero. A Participant shall receive no refund of amounts which are not incurred and substantiated ~~or used~~ during a Plan Year and for which a claim for reimbursement is not submitted within the time period provided for in Section 8.3, for any reason.

6.5 Waiver of Future Benefits. Each employee who participates in this Plan is permitted to permanently opt out of and waive future Benefits and reimbursements from the Plan at any time. Further, upon termination of employment, the Employee is allowed to permanently opt out of and waive future Benefits and reimbursements from the Plan.

~~ARTICLE VI~~ARTICLE VII~~ARTICLE VI~~
ADMINISTRATION

~~6.1~~7.1 ~~6.1~~ Administrator. The Employer shall be the Plan Administrator of the Plan ~~for purposes of ERISA~~; however, the Employer reserves the right to appoint any person or entity, including an employee of the Employer, to administer the Plan on its behalf.

~~6.2~~7.2 ~~6.2~~ Fiduciary. The Employer shall be the fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer's responsibility to an employee of Employer, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

~~6.3~~7.3 ~~6.3~~ Rules of Administration. The Employer may adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

~~6.4~~7.4 ~~6.4~~ Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical, claims administration and other services to carry out the Plan. The costs of such services and other administrative expenses shall be paid by the Employer.

~~6.5~~7.5 ~~6.5~~ Funding Policy. The Employer may periodically, at its discretion, review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

~~6.6~~7.6 ~~6.6~~ Claims Procedure.

(a) To receive benefits under the Plan, a Participant must submit a written claim for benefits to the Plan Administrator.

The Plan Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan or has not been advised of his Benefits, he may submit a written request to the Plan Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Plan Administrator must respond to such a request within a reasonable time.

Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating in a format determined to be understood by the claimant:

(1) the specific reason or reasons for the denial;

(2) specific reference to pertinent plan provisions on which the denial is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim; and

(4) an explanation of the claim review procedure set forth in Paragraph (b) below.

(b) Within sixty (60) days of receipt by a claimant of a notice denying a claim under Paragraph (a), the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator or by the Administrator which may be appointed by the Employer for that purpose. The Plan Administrator may extend the sixty (60) day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Plan Administrator or Administrator shall make a decision promptly, and not later than 60 days after the Plan Administrator's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the Administrator deems one necessary) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than one hundred twenty (120) days after receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

~~6.7~~7.7 ~~6.7~~ Nondiscriminatory Operation. All rules, decisions and designations by the Employer and each administrative committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

~~6.8~~7.8 ~~6.8~~ Liability of Administrative Personnel. Neither the Employer, nor any of its employees, nor any provider of services under Section ~~6.4~~7.4 herein, shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility, if one is owed, with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

7.9 Use of Electronic Medium for Participant Notices.

a. Definition of Electronic Medium. "Electronic Medium" means an electronic method of communication between the Plan Administrator (or its designated representative) and Employee thereby allowing each party to send and receive notices 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 than is readily understandable. The electronic medium shall be designed to preclude any person, other than the appropriate individual, from making a Participant election 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 Plan 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 related 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 Plan 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 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 Plan 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.

~~ARTICLE VII~~ARTICLE VIII~~ARTICLE VII~~
PAYMENT OF BENEFITS

~~7.1~~8.1 ~~7.1~~ Claims for Benefits. No benefit shall be paid under the Plan unless a Participant has first submitted a written claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in Section ~~7.2~~8.2.

~~7.2~~8.2 ~~7.2~~ Reimbursement of Eligible Medical Expenses. Each Participant who desires to receive reimbursement under the Plan for Eligible Medical Expenses shall submit to

the Plan Administrator, at the times indicated in Section ~~7.3~~8.3, on a form provided by the Employer, or responses to other supplementary factual requests, containing the following information:

(a) the name of the person or persons on whose behalf Eligible Medical Expenses have been incurred;

(b) the nature of the expenses so incurred;

(c) the date of the expenses so incurred;

(d) the amount of the requested reimbursement; and

(e) that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

As soon as is administratively feasible at the beginning of each month during the Plan Year, the Plan Administrator or his designated claims administration representative shall review all the claim forms submitted by Participants during the prior month in accordance with the foregoing procedures and shall pay each Participant the Benefit Credits which each Participant is entitled to receive under the Plan.

~~7.3~~8.3 ~~7.3~~ Time Limit. No expense shall be reimbursed for any Plan Year unless the Participant submits a claim for such reimbursement within ninety (90) days after the end of such Plan Year or ninety (90) days following a Participant's date of termination of participation.

~~7.4~~8.4 ~~7.4~~ Source of Benefit Payments. The sole source for payment of benefits under this Plan shall be the unfunded accounts established for each Participant pursuant to Article ~~V~~VI. The Plan Administrator shall pay to each Participant the benefits which he is entitled to receive under this Plan, and his reimbursement account under the Plan shall be debited accordingly. A Participant shall not be entitled to receive reimbursement for any Eligible Expenses or any portion thereof which exceeds the Participant's total Benefit Credits for a Plan Year.

~~ARTICLE VIII~~ARTICLE IX~~ARTICLE VIII~~
CONTINUATION OF COVERAGE

~~8.1~~9.1 ~~8.1~~ In General. During any Plan Year during which the Employer has 20 or more Employees, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan pursuant to the continuation coverage provisions of the Public Health Service Act, as set forth in 42 U.S.C. §300bb et seq., and any amendments thereto.

~~8.2~~9.2 ~~8.2~~ Definitions. For purposes of this Article ~~VIII~~IX, the following words and phrases are intended to supplement, and in some instances replace, the defined

terms listed generally in Article ~~III~~II and to the extent of any conflict between the terms set forth herein and those of Article ~~III~~II, the defined terms set forth herein shall control:

(a) "Dependent" means an individual who meets the definition of dependent under this Plan.

(b) "Election period" means the sixty (60) day period following the Qualifying Event during which a Qualified Beneficiary may elect continuation coverage. This sixty (60) day period begins not later than the date of termination of coverage 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" means an individual who, on the day before the Qualifying Event, is covered under this Plan as the covered Employee, the spouse of the covered Employee or dependent child of the covered Employee, and loses coverage under the Plan as a result of the Qualifying Event. Qualified Beneficiary shall also 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.

(d) "Qualifying Event" means with respect to a covered Employee, any of the following events which results in the loss of coverage of 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); (5) a dependent child who ceases to be a Dependent under the terms of this Plan; or (6) the Employer's filing for Chapter 11 reorganization as it would affect retiree coverage.

~~8.3~~9.3 ~~8.3~~ Continuation Coverage. To the extent required by Section ~~8.1~~9.1 above, a Qualified Beneficiary is entitled to elect continuation coverage pursuant to the timing requirements of this Article ~~VIII~~IX. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required. Unless otherwise specified in the 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 on behalf of any Qualified Beneficiaries who are Dependents of the Employee or spouse.

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.

~~8.4~~9.4 ~~8.4~~ Limitations on Continuation Coverage; Length of Coverage.

(a) Unavailability Of Continuation Coverage. Continuation coverage under this Plan shall not be offered if the Participant's remaining Benefit Credits in his spending account is zero on the date of the Qualifying Event.

(b) Limited Continuation Coverage. If a Participant is showing a remaining balance of Benefit Credits in his spending account as of the date of the Qualifying Event, the Employer shall offer continuation coverage under the Plan for the remainder of the Plan Year for the year in which the Qualifying Event occurred.

~~8.5~~9.5 ~~8.5~~ Notification Requirements.

(a) Notification by Qualified Beneficiary. Within sixty (60) days, each Qualified Beneficiary must notify the Employer of the occurrence of either the divorce or legal separation of the Employee or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan.

(b) Notification to Qualified Beneficiary.

(1) Upon commencement of participating in the Plan, the Administrator shall provide written notice to each covered Employee and his Spouse of the right to continuation coverage under the Plan.

(2) Within fourteen (14) days of receiving notice of the occurrence of a Qualifying Event, the Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under the Plan. Notification 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.

~~8.6~~9.6 ~~8.6~~ Termination of Continuation Coverage. The continuation coverage provided hereunder shall be terminated prior to the last day of the Plan Year in which the Qualified Beneficiary experiences the Qualifying Event if the Qualified Beneficiary fails to make timely payment of the required contribution.

~~8.7~~9.7 ~~8.7~~ Contribution. The monthly cost or the premium for coverage hereunder shall be calculated as follows: "the total amount of the monthly Employer Allowance." 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. A Qualified Beneficiary may elect to pay such premium in monthly installments. Notwithstanding, for an election made during the Election Period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election provided payment is made within forty-five (45) days of the date of the election.

~~ARTICLE IX~~ARTICLE X~~ARTICLE IX~~
MISCELLANEOUS

~~9.1~~10.1~~9.1~~ Amendment and Termination. The Employer may amend or terminate this Plan at any time by action of the Employer. The Employer may amend or modify this Plan retroactively to enable the Plan to provide non-taxable medical expense reimbursement benefits under Section 105 of the Code. No amendment shall deprive any Participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

~~9.2~~10.2~~9.2~~ Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment or reemployment between the Employer and any Participant or to be a consideration or an inducement for the reemployment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer.

~~9.3~~10.3~~9.3~~ Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

~~9.4~~10.4~~9.4~~ Payments to Beneficiary. Any benefits otherwise payable to a Participant or his or her Dependents following the date of death of such Participant or his or her Dependents relating to a claim arising before his or her death shall be paid to his or her spouse, or, if there is no surviving spouse, to the Participant's or Dependent's estate.

~~9.5~~10.5~~9.5~~ Facility of Payment. If the Employer deems any person incapable of receiving benefits to which he or she is entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete acquittance therefor. Such payments shall, to the extent thereof, discharge all liability of the Employer.

~~9.6~~10.6~~9.6~~ Proof of Claim. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require (either directly to the Employer or to any person delegated by it).

~~9.7~~10.7~~9.7~~ Status of Benefits. The Employer believes that this Plan is written in accordance with Section 105 of the Code and that it provides certain benefits to Employees 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.

~~9.8~~10.8~~9.8~~ Applicable Law. The Plan shall be construed and enforced according to the laws of the State of California to the extent not pre-empted by any federal law.

~~9.9~~10.9~~9.9~~ Lost Distributees. Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit.

~~9.10~~10.10 ~~9.10~~ Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

~~9.11~~10.11 ~~9.11~~ Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

~~9.12~~10.12 ~~9.12~~ Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

~~9.13~~10.13 ~~9.13~~ Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

~~9.14~~10.14 ~~9.14~~ Source of Payments. The Employer shall be the sole source of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer 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 Employee or beneficiary.

ARTICLE XI
HIPAA PRIVACY STANDARDS

11.1 Employer's Certification of Compliance. The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 C.F.R. § 164.504(f)(2)(ii), and that Employer agrees to conditions of disclosure set forth in this Article XI.

11.2 Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Employer or the Administrator information on whether the individual is participating in the Plan.

11.3 Permitted Uses and Disclosures of Summary Health Information. The Plan may disclose Summary Health Information to the Employer or the Administrator, provided that the Employer or the Administrator requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information that (1) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 C.F.R. § 164.5 14(b)(2)(i) has

been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

11.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article XI (including, but not limited to the restrictions on Employer's use and disclosure described in 10.5) and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

11.5 Restrictions on Employer's Use and Disclosure of Protected Health Information.

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to Protected Health Information.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.

(e) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

11.6 Adequate Separation Between Employer and the Plan.

(a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information received from the Plan or a business associate servicing the Plan: Privacy Official, employees in the Employer's Human Resources Department; and any other class of employees designated in writing by the Privacy Official.

(b) The employees, classes of employees or other workforce members identified in Section 11.6(a), above, will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 11.5(a), above.

(c) The employees, classes of employees or other workforce members identified in Section 11.6(a), above, will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information in breach or violation of or noncompliance with the provisions of this Article XI.

IN WITNESS WHEREOF, the Employer has caused this Medical Expense Reimbursement Plan to be executed on January ____, 2014.

EMPLOYER:

RUNNING SPRINGS WATER DISTRICT

By: _____
Name: _____
Title: _____

APPROVED AS TO FORM AND CONTENT:

BEST BEST & KRIEGER LLP

By: _____
Attorneys for Employer