



RFA GOVERNANCE BOARD REGULAR MEETING AGENDA

10:00 A.M. – Monday, September 14, 2026

Fire Station #13, 18002 108th Ave SE, Renton, WA 98055

Zoom Webinar: <https://us02web.zoom.us/j/81206829662>

Dial-in: (253) 215-8782 | Webinar ID: 812 0682 9662

- Call Meeting to Order
- Flag Salute
- Roll Call
- Agenda Modifications
- Announcements, Proclamations, and Presentations
- Public Comment

Members of the audience may comment on items relating to any matter related to RFA business under the Public Comment period. Comments are limited to three (3) minutes per person pursuant to the rules established under Section 8 of the bylaws.
- Consent Agenda
 - Approval of [Minutes from August 10, 2026](#), Regular Meeting
 - Approval of [Vouchers](#): AP Check Register 7/1/2026 – 7/31/2026
Payroll Checklist 7/1/2026 – 7/31/2026
- Signing of Vouchers
- Board Committee Reports
 - Budget & Finance Committee
 - Operations and Capital Committee
- [Chief's Report](#)
- Division Reports
 - Administration (CAO Babich)
 - EMS/Health & Safety (Deputy Chief Alexander)
 - Office of the Fire Marshal (Fire Marshal Barton)
 - [OFM Monthly Report](#)

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- Support Services (Deputy Chief Simonds)
- Response Operations (Deputy Chief Seaver)
 - Significant Events
 - 8/4/26 51 Burnett Ave S Stabbing Incident
 - 8/4/26 330 Vuemont Pl NE Commercial Fire
 - 8/4/26 4300 Block of SE 4th Pl Residential Fire
 - 8/7/26 1600 Block of SE 116th St Residential Fire
 - 8/9/26 3004 SE 12th St Brushfire
 - 8/15/26 18230 East Valley Hwy Stabbing Incident
 - 8/17/26 3000 SE Royal Hills Dr Brushfire
 - 8/20/26 300 SW 41st St Shooting Incident
 - 8/20/26 16700 Block of 126th Ave SE Drowning Incident
 - Training
 - Olympic Pipeline Tour & Foam Application Drill
 - Passenger Vehicle Rescue
 - Active Shooter Drill @ Kentlake High School
 - Tech Rescue: Paratech Strut Training
 - Public Outreach
 - National Night Out
 - Engine Visits: Kenworth Truck Company Family Day, Childtime Daycare, Fairwood Market, Sunset Neighborhood Association, Renton Family First Community Center, Carriage Crest Elementary, Daddy Stroller Social Club, Fairwood Anniversary Celebration
 - Station Tour: ST 11
 - Ride Alongs
 - [August Response Reports](#)
- Correspondence
- Unfinished Business
- New Business
 - [Resolution 2026-03](#) Authorization of Purchases From and Through the United States Government
 - [Resolution 2026-04](#) Adoption of the IAFF Health & Wellness Trust HRA Benefit Plan
 - [Resolution 2026-05](#) Approving the Master Services Agreement and HIPAA Business Associate Agreement for the FSA Benefit Plan
 - [Resolution 2026-06](#) Bid Exemption for AI/HPC Hardware Procurement

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- Good of the Order
- Executive Session
- Future Meetings:
 - Monday, September 28, 2026, 10:00 a.m., Budget/Finance Committee Meeting, Video Conference
 - Monday, September 28, 2026, 10:30 a.m., Operations/Capital Committee Meeting, Video Conference
 - Monday, October 12, 2026, 10:00 a.m., Governance Board Regular Meeting, Fire Station #13 (18002 108th Ave SE, Renton) / Video Conference
- Adjournment



Renton Regional Fire Authority

18002 108th Ave SE

Renton, WA 98055

Office: (425) 276-9500

Fax: (425) 276-9592

MINUTES

RFA Governance Board Regular Meeting

10:00 A.M. – Monday, August 10, 2026

Fire Station #13 – 18002 108th Ave SE, Renton

CALL TO ORDER

Governance Board Chair Cook called the regular meeting to order at 10:01 a.m.

ROLL CALL

Governance Board Members Present:

Sean Cook, Chair (Fire District 25)

Ed Prince, Vice Chair (City of Renton)

Andy Adolfson (Fire District 25)

Ryan McIrvine (City of Renton)

Steve Parsons (Fire District 40)

Linda Sartnurak (Fire District 40)

Governance Board Members Not in Attendance:

Ruth Pérez (City of Renton)

Administrative Staff Present:

Fire Chief Steve Heitman, Chief Administration Officer Samantha Babich, Fire Marshal Anjela Barton, Deputy Chief Mark Seaver, Deputy Chief Dan Alexander, Deputy Chief Ryan Simonds, Facilities Technician Don Highley, and Board Secretary Samantha Vergara

Public Present Online:

Michael Miller

A **MOTION** was made by Board Member Sartnurak and **SECONDED** by Board Member Adolfson to excuse the absent board member. **MOTION CARRIED (6-0)**

AGENDA MODIFICATIONS

There were no agenda modifications.

ANNOUNCEMENTS, PROCLAMATIONS, AND PRESENTATIONS

Capital Facilities Plan and Rate Study

CAO Babich gave a high-level summary of both the CFP and Rate Study, which were shared in detail during the July committee meetings. CAO Babich noted the one major change from last year's rate study is the law changed to impact fees being collected per square foot vs per residential unit or commercial property.

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PUBLIC COMMENT

There was no public comment.

CONSENT AGENDA

Approval of minutes from the July 13, 2026, regular meeting and the approval of vouchers.

A **MOTION** was made by Board Member Sartnurak and **SECONDED** by Board Member McIrvine to approve the consent agenda for August 10, 2026. **MOTION CARRIED (6-0)**

SIGNING OF VOUCHERS

The governance board members signed the voucher approval letter for August 10, 2026.

BOARD COMMITTEE REPORTS

Board Member Adolfson, the Budget/Finance Committee Chair, noted the July 27, 2026, committee meeting took place and there was nothing to report.

Board Member Parsons, the Operations/Capital Committee Chair, noted the July 27, 2026, committee meeting took place and there was nothing to report.

CHIEF'S REPORT

Chief Heitman presented his report, which included welcoming RRFA's newest member, Anna DeSmith, in her role as Deputy Fire Marshal.

DIVISION REPORTS

EMS/Health & Safety

DC Alexander informed the board that Renton RFA received a \$25K grant for the Resilience Program, through L&I's Firefighter Injury and Illness Reduction (FIIRE) Program – a safety initiative for employers of professional firefighters.

Office of the Fire Marshal

Fire Marshal Barton presented the OFM monthly report.

Response Operations

DC Seaver presented the Response Operations monthly report.

CORRESPONDENCE

There was no correspondence.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

Establish Public Hearing Dates for Property Tax Levy and FBC and Budget Calendar

Renton RFA proposes a special meeting on Oct. 26, 2026, in lieu of the committee meetings to hold a public hearing on the proposed levy and fire benefit charge. This meets the required deadlines for filing property tax levy and fire benefit charge information with King County.

A **MOTION** was made by Board Member Adolfson and **SECONDED** by Board Member Parsons to establish the dates and hold a special meeting as requested. **MOTION CARRIED (6-0)**

GOVERNANCE BOARD REGULAR MEETING MINUTES

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Board Secretary Vergara inquired about the proposed meeting time, whether it will be held at 10:00 a.m. instead of the noted 11:00 a.m. Attending board members were asked if their schedules aligned for a 10:00 a.m. start and all confirmed yes.

Resolution 2026-02 Adopting the 2027 Capital Facilities Plan and Rate Study

Renton RFA is required by ILA agreement with the City of Renton to have a Capital Facilities Plan for the purpose of imposing impact fees on development within the city limits. In conjunction with this, a rate study was conducted to accurately align the rates for impact fees.

A **MOTION** was made by Board Member McIrvine and **SECONDED** by Board Member Parsons to approve Resolution 2026-02 to adopt the 2027 CFP and Rate Study as presented. **MOTION CARRIED (6-0)**

2027 Dental Plan Updates for Fire Districts #25 and #40

A request was made to amend the LEOFF I dental insurance plans to add orthodontic service during Trusted Plan Service Corp's open enrollment period occurring between October and November.

A **MOTION** was made by Board Member Parsons and **SECONDED** by Board Member McIrvine to approve the addition of orthodontia to the dental plan as presented. **MOTION CARRIED (5-0) with one member abstaining.**

GOOD OF THE ORDER

Board Member Parsons gave notice of his availability in the upcoming month and will be unable to attend the Sept. 14, 2026, regular governance board meeting or the Sept. 28, 2026, Operations/Capital committee meeting. Board Secretary Vergara gave notice to the board that she is unable to join the Aug. 24, 2026, committee meetings. CAO Babich will host instead.

EXECUTIVE SESSION

There was no executive session.

FUTURE MEETINGS

- Monday, August 24, 2026, 10:00 a.m., Budget/Finance Committee Meeting, Video Conference
- Monday, August 24, 2026, 10:30 a.m., Operations/Capital Committee Meeting, Video Conference
- Monday, September 14, 2026, 10:00 a.m., Governance Board Regular Meeting, Fire Station #13 (18002 108th Ave SE, Renton) / Video Conference

ADJOURNMENT

Board Chair Cook adjourned the meeting at 10:26 a.m.

Sean Cook, Board Chair

Samantha Vergara, Board Secretary

VOUCHER APPROVAL FOR SEPTEMBER 14, 2026 MEETING

AUDITING OFFICER CERTIFICATION

I, the undersigned, do hereby certify under penalty of perjury that the materials have been furnished, the services rendered, or the labor performed as described herein, that any advance payment is due and payable pursuant to a contract or is available as an option for full or partial fulfillment of a contractual obligation, and that the claim is a just, due and unpaid obligation against the Renton Regional Fire Authority, and that I am authorized to authenticate and certify said claim.

Auditing Officer: _____

Steven C. Heitman, Fire Chief

AUDIT COMMITTEE

The vouchers below have been reviewed and certified by individual departments and the RFA's Auditing Officer as required by RCW's 42.24.080 & 090, and a list of vouchers has been provided for review by the Finance Committee.

The undersigned members of the Finance Committee of the Renton Regional Fire Authority do hereby approve for payment accounts payable vouchers totaling \$4,951,581.81, payroll vouchers and direct deposits totaling \$1,774,637.16.

A/P VOUCHERS	Payment Date	Numbers	Amount
Virtual Pay	07/01/2026 - 07/31/2026	APA006045-APA006131	\$3,107,820.42
Checks	07/01/2026 - 07/31/2026	13880-13880	\$3,314.80
EFTs	07/01/2026 - 07/31/2026	-	\$442,003.01
Bank Drafts	07/01/2026 - 07/31/2026	-	\$1,398,443.58
AR Refund Checks	07/01/2026 - 07/31/2026	0-0	\$0.00
TOTAL A/P			\$4,951,581.81
PAYROLL VOUCHERS	Payment Date	No. of Vouchers	Amount
Direct Deposit	7/24/2026	181	\$879,370.16
Check	7/24/2026	3	\$0.00
Direct Deposit	8/10/2026	188	\$895,267.00
Check	8/10/2026	2	\$0.00
TOTAL PAYROLL		374	\$1,774,637.16
TOTAL CLAIMS			\$6,726,218.97

Renton Regional Fire Authority Governance Board:

Steve Parsons, Board Member

Sean Cook, Board Chair

Ruth Pérez, Board Member

Andy Adolfson, Board Member

Ed Prince, Board Vice-Chair

Ryan McIrvine, Board Member

Linda Sartnurak, Board Member

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RENTON REGIONAL FIRE AUTHORITY

M E M O R A N D U M

DATE: September 14, 2026

TO: Andy Adolfson (Fire District 25)
Sean Cook (Fire District 25)
Ryan McIrvine (City of Renton)
Steve Parsons (Fire District 40)
Ruth Pérez (City of Renton)
Ed Prince (City of Renton)
Linda Sartnurak (Fire District 40)

FROM: Steve Heitman, Fire Chief

SUBJECT: Renton Regional Fire Authority Chief's Report

1. Journeyman Status Completions

I'm pleased to share that Firefighter Clint Farina has successfully completed his probationary period and achieved journeyman status with Renton Regional Fire Authority. This milestone is achieved by completing JATC training and three years with Renton RFA, and reflects a member's dedication, hard work, and commitment to serving our community at the highest standard. Please join me in congratulating FF Farina on this important professional achievement.

2. 2026 Station Open Houses

Our annual open houses are scheduled for the following dates/times for each fire station. These events offer civilians the chance to meet local firefighters and learn about fire safety and emergency preparedness. We have secured the permit for the traffic revisions at Station 17 and the flagging company. The Zone 3 Fire Cadets will also be secured for this event. A [save-the-date flyer](#) insert was included in the newsletter that went out in August to all Renton RFA citizens.

- | | | |
|--------------|--------------------------|------------------|
| • Station 11 | October 17 th | 9:00am – 11:00am |
| • Station 12 | October 17 th | 1:00pm – 3:00pm |
| • Station 13 | October 24 th | 9:00am – 11:00am |
| • Station 15 | October 24 th | 1:00pm – 3:00pm |
| • Station 16 | October 31 st | 9:00am – 11:00am |
| • Station 17 | October 31 st | 1:00pm – 3:00pm |

3. Hiring Update

We have pulled names from Public Safety and are in the process of conducting 220 panel interviews for the entry-level firefighter position the week of September 21st, with 55 candidates moving to Chief interviews scheduled the week of October 12th. We intend to make ten job offers for the February academy.

4. Family First Community Center Back-to-School Event

On August 15, 2026, Renton RFA attended the third annual Family First Community Center Back-to-School event. This event brought together approximately 1,500 community members as well as local public service agencies, non-profits, and businesses to provide resources to students and families as they gear up for a new school year. Outside the event, Renton firefighters answered community member questions, provided engine tours, and handed out hundreds of stickers. Inside the event, Renton RFA civilian staff hosted a booth with a fun Q&A activity and hiring information, and handed out free safety lights and first aid kits to students and their families to promote safety and visibility as kids return to school. Family First Community Center founder and former Seattle Seahawk Doug Baldwin was active at the event and stopped to share his gratitude with the firefighters for the agency's participation and support. Renton RFA was already invited back for the 2027 event.



YOU'RE INVITED!

We're delighted to invite you to our annual open houses happening the last three Saturdays in October (see our schedule below).

Each event will feature unique activities and the opportunity to meet your local firefighters; check out the fire stations; get hands-on with fire trucks, aid units, and equipment; learn more about fire safety and fire careers; and take home great safety swag!

Our open houses occur indoors, so they're a great fall activity, rain or shine! We have something for everyone, so bring your curiosity, and we'll supply the fun!

Activities for the whole family!



- Meet your local firefighters
- Tour the fire engines & aid units
- Try out fire equipment
- Learn fire safety & careers
- Spray the fire hose
- Collect safety swag
- Unique activities at each station

RENTON FIRE OPEN HOUSES

October 17, 2026

 **Fire Station 11**.....9 AM - 11 AM
211 Mill Ave S, Renton, WA 98057

 **Fire Station 12**.....1 PM - 3 PM
1209 Kirkland Ave NE, Renton, WA 98056

October 24, 2026

 **Fire Station 13**.....9 AM - 11 AM
18002 108th Ave SE, Renton, WA 98055

 **Fire Station 15**.....1 PM - 3 PM
1404 N 30th St, Renton, WA 98056

October 31, 2026

 **Fire Station 16**.....9 AM - 11 AM
12923 156th Ave SE, Renton, WA 98059

 **Fire Station 17**.....1 PM - 3 PM
14810 SE Petrovitsky Rd, Renton, WA 98058

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Join the fun!

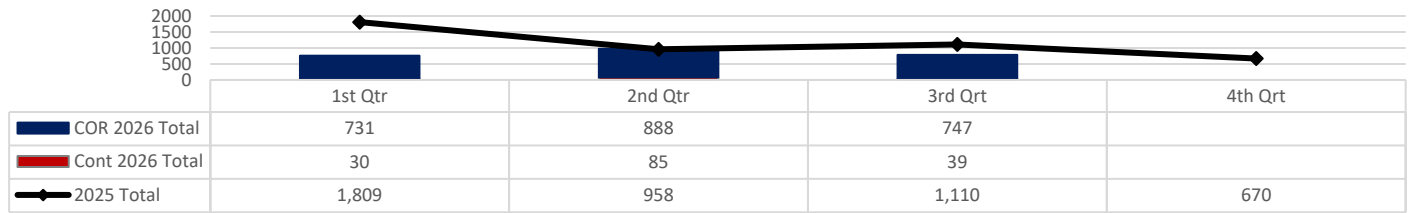


Office of the Fire Marshal Monthly Report August 2026

Inspections

Staff have completed 2,520 inspections (business, multi-family, IFC permit, special, complaint & re-inspections) YTD.

Inspections Completed by Quarter - Comparative to 2025



Fire Safe Business of the Month

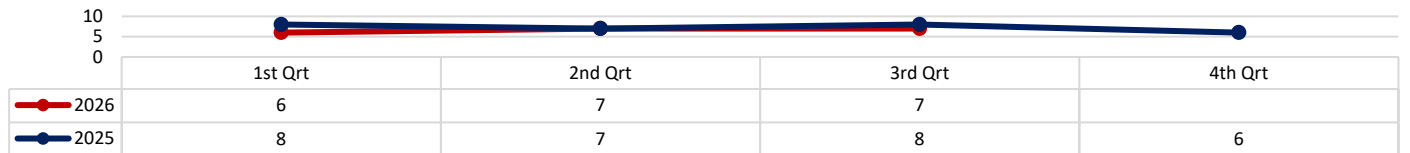
Fabrics for Less was selected as the Fire Safe Business of the Month based on their recent fire and life safety inspection and their continued commitment to providing a fire safe environment for their employees and patrons.



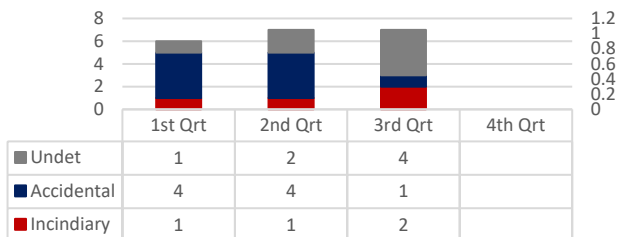
Fire Investigations

There were four fires in August that met the threshold for a fire investigator. Total dollar loss for the year is estimated at \$5m and an estimated \$136m in saved property.

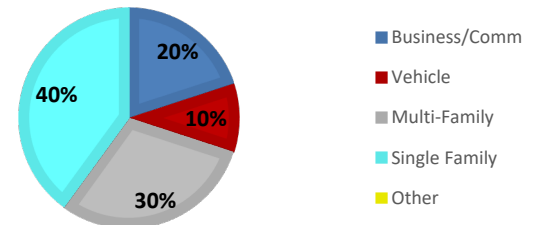
Fire Investigations by Quarter - Comparative to 2025



FIRE CAUSE DETERMINATION



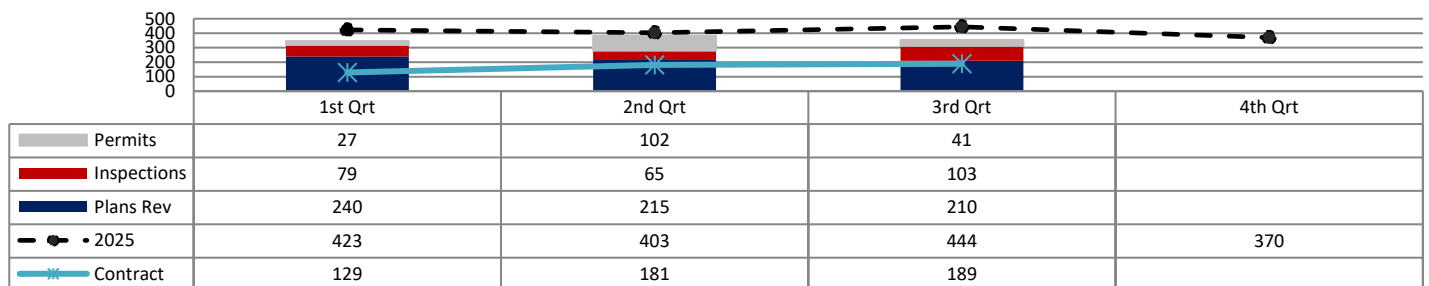
PROPERTY TYPE OF INVESTIGATED FIRES



Plans Review, Construction Inspections & Permits

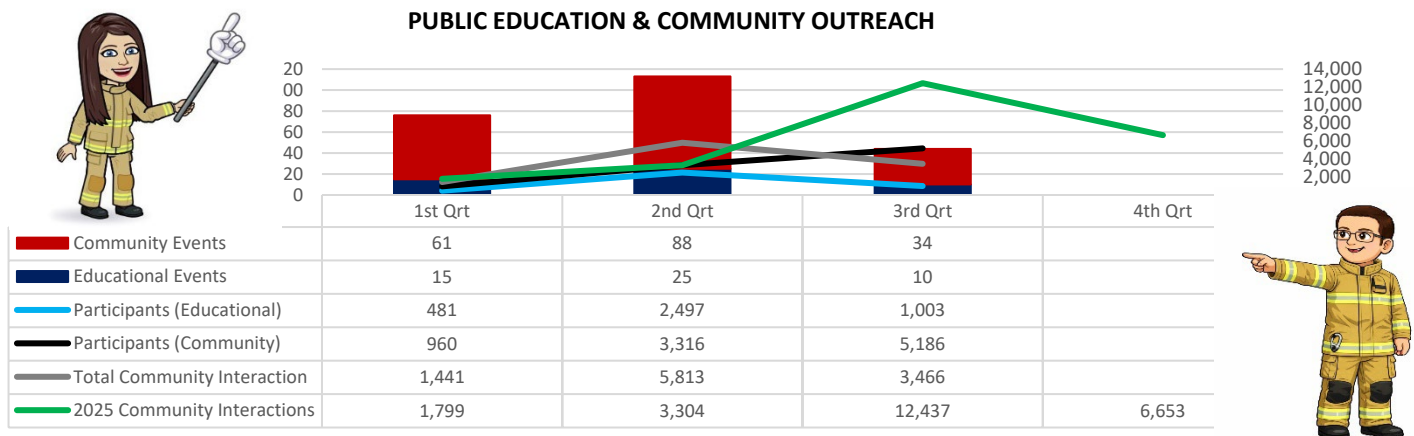
Staff completed 837 plans reviews, 402 construction inspections and issued 367 fire permits YTD.

Plans Review, Construction Inspections & Permits by Quarter - Comparative to 2025



Public Education / Community Outreach Highlights

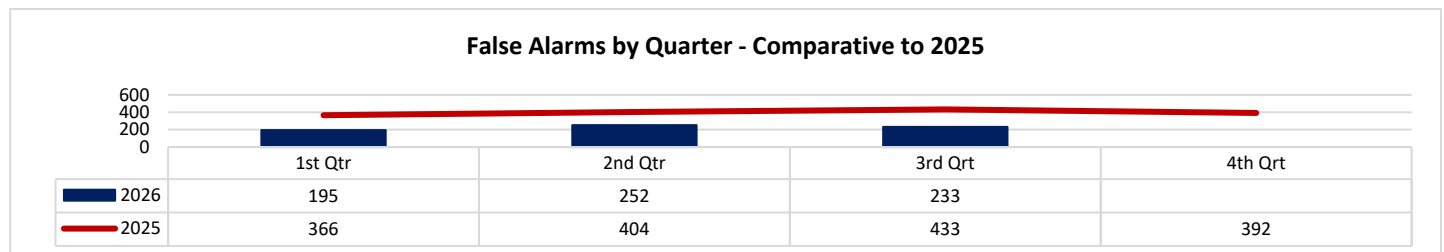
We've participated in 50 educational events (3,981 attendees) and an additional 183 community events (9,462 attendees) YTD.



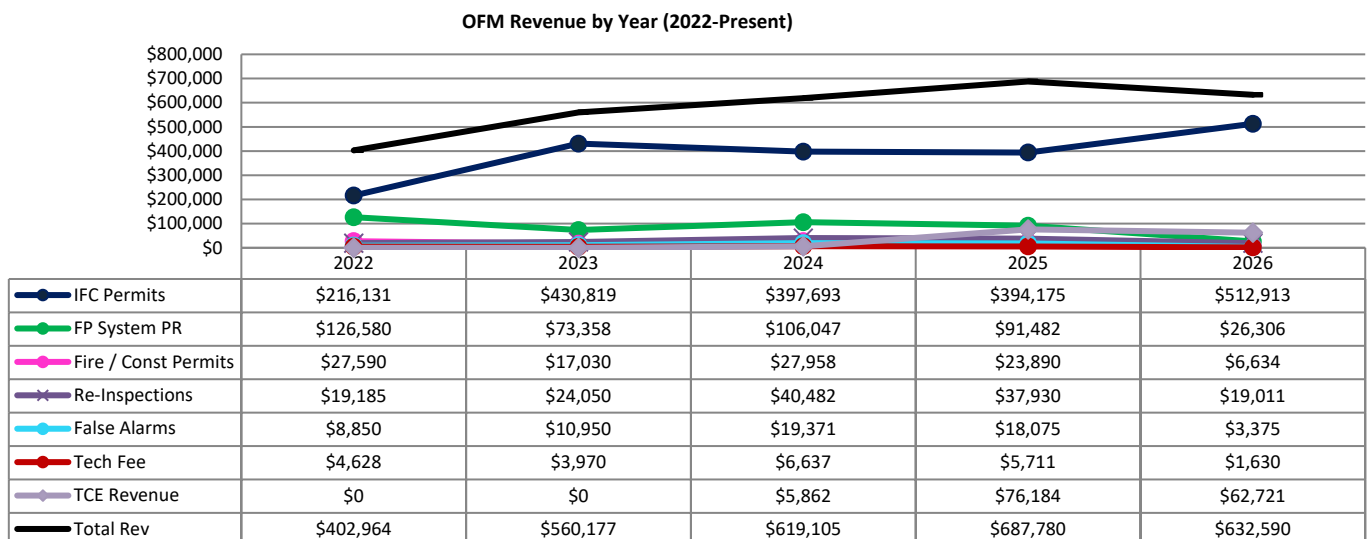
- In partnership with Renton PD, participated in National Night Out, attended by an estimated 644 community members.
- Partnered with Renton EM in the "Playing with Fire" fire safety class, attended by 34 students.

False Alarms

The Department responded to 680 false alarms within our response area year-to-date.



OFM Revenue. OFM revenues year to date are \$632,590.





RRFA Governance Board Response Operations Report

Board meeting: 2026 / 09 - Sep | Data month: 08 - Aug 2026

Incident Breakdown by Station (Including Out of Jurisdiction)

Incident Type	11	12	13	14	15	16	17	Total
Alarms non medical	7	11	14	7	4	2	4	42
Cancelled	17	7	6	13	6	4	7	53
Citizen assist	7	10	4	0	4	6	4	32
Disaster weather	1	0	0	0	0	0	0	1
False alarm	15	20	20	27	13	17	9	113
Good intent	1	1	3	5	2	1	4	15
Hazard non chemical	5	2	2	3	1	1	1	13
Hazardous materials	1	4	5	7	1	2	0	11
Illness	188	159	239	91	62	79	162	953
Injury trauma	105	76	99	36	21	27	47	353
Investigation	5	9	12	9	6	4	4	34
Law enforcement support	1	0	0	0	0	0	0	1
Medical other	4	6	1	0	0	0	2	13
Other	2	2	5	0	2	1	3	14
Outside fire	21	12	14	8	6	6	11	64
Outside rescue	0	1	0	0	0	0	0	1
Public service other	0	1	0	0	1	0	0	1
Special fire	0	0	0	0	0	0	1	1
Structure fire	6	5	11	1	4	5	7	14
Structure rescue	4	1	3	1	0	0	0	7
Transportation fire	2	2	1	0	3	0	0	6
Water rescue	0	1	0	0	0	0	0	1
Total	392	330	439	208	136	155	266	1743

Totals are distinct incident counts, not column sums — an incident with units at two stations counts in both columns.

Response Breakdown by Station's Units (Including Out of Jurisdiction)

Unit	Responses
Station 11	463
A311	227
E311	172
L311	64
Station 12	396
A312	201
B312	41
CAR312	9
E312	143
WR312	2
Station 13	505
A313	287
A413	2
B313	59
E313	156
E413	1
Station 14	213
E314	198
HM314	15
Station 15	137
E315	137
Station 16	155
BR316	1
E316	154
Station 17	288
A317	177
BR317	4
E317	107
Total	2157

Station Reliability (Not Including Out of Jurisdiction)

Station Area	1st Due Incidents	In-Area Incidents	Reliability
11	298	308	96.75%
12	270	312	86.54%
13	353	385	91.69%
14	137	148	92.57%
15	82	94	87.23%
16	116	133	87.22%
17	222	230	96.52%
Total	1478	1610	91.80%

Reliability = % of in-area incidents where the first-due station's unit responded. Grouped by owning area (First Due AM).

Last Month Response Time Breakdown (In-Jurisdiction)

Apparatus / Station	Avg Turnout	Avg Travel	Avg Response	90th Turnout	90th Travel	90th Response
Station 11	01:51	03:55	05:46	02:41	07:06	09:13
Aid Unit	01:57	03:30	05:27	02:45	06:22	08:49
Engine	01:48	04:13	06:01	02:35	07:05	09:21
Ladder Truck	01:37	04:51	06:28	03:01	09:45	10:58
Station 12	01:54	03:16	05:10	03:03	05:48	08:11
Aid Unit	01:50	03:00	04:50	03:00	05:02	07:33
Engine	01:59	03:38	05:37	03:05	06:50	09:26
Station 13	01:35	04:25	06:00	02:34	06:53	08:38
Aid Unit	01:31	04:09	05:41	02:31	06:19	08:03
Engine	01:44	04:54	06:38	02:36	08:09	10:07
Station 14	02:20	04:10	06:30	03:02	06:39	08:42
Engine	02:20	04:10	06:30	03:02	06:39	08:42
Station 15	01:57	04:44	06:41	02:46	07:51	09:23
Engine	01:57	04:44	06:41	02:46	07:51	09:23
Station 16	01:52	04:32	06:24	02:41	07:09	09:08
Engine	01:52	04:32	06:24	02:41	07:09	09:08
Station 17	01:41	04:09	05:50	02:40	06:05	07:57
Aid Unit	01:40	04:06	05:46	02:41	06:09	08:03
Engine	01:42	04:15	05:56	02:37	05:59	07:45
Total	01:50	04:04	05:54	02:47	06:42	08:45

Turnout = dispatch to enroute; Travel = enroute to on-scene; Response = dispatch to on-scene. Times shown MM:SS.

YTD Incident Counts by RRFA Station Area (Not Including OOJ)

First Due AM	01 - Jan	02 - Feb	03 - Mar	04 - Apr	05 - May	06 - Jun	07 - Jul	08 - Aug	Total
11	318	276	270	333	373	343	385	308	2606
12	275	308	310	308	269	354	328	312	2464
13	396	347	410	431	400	387	399	385	3155
14	131	112	148	113	147	153	153	148	1105
15	67	54	83	78	81	110	105	94	672
16	129	99	152	134	132	134	135	133	1048
17	167	179	224	182	222	203	244	230	1651
Total	1483	1375	1597	1579	1624	1684	1749	1610	12701

YTD Incident Counts by NFIRS Incident Type (Including OOJ)

Core primary incident type subcategory	01 - Jan	02 - Feb	03 - Mar	04 - Apr	05 - May	06 - Jun	07 - Jul	08 - Aug	Total
Alarms non medical	64	78	59	60	53	54	45	42	455
Cancelled	53	58	50	48	59	61	66	53	448
Citizen assist	46	32	41	43	27	31	30	32	282
Disaster weather	2	1	24	1	4	7	0	1	40
False alarm	57	58	91	70	81	117	134	113	721
Good intent	11	12	13	12	15	18	15	15	111
Hazard non chemical	19	12	28	18	7	24	17	13	138
Hazardous materials	17	7	6	6	12	8	15	11	82
Illness	977	878	997	959	993	983	1014	953	7754
Injury trauma	283	273	346	357	378	342	383	353	2715
Investigation	19	19	15	23	17	29	31	34	187
Law enforcement support	2	1	1	2	1	0	1	1	9
Medical other	11	15	18	16	14	26	24	13	137
Other	2	6	1	5	10	9	9	14	56
Outside fire	17	12	23	29	37	61	90	64	333
Outside rescue	0	0	1	1	0	2	0	1	5
Public service other	2	0	6	1	1	0	2	1	13
Special fire	0	0	1	1	1	1	0	1	5
Structure fire	10	7	11	12	8	15	9	14	86
Structure rescue	4	3	5	7	5	11	6	7	48
Transportation fire	8	4	5	12	4	3	6	6	48
Transportation rescue	0	0	1	1	0	0	2	0	4
Water rescue	0	1	4	0	5	5	6	1	22
Total	1604	1477	1747	1684	1732	1807	1905	1743	13699

YTD Responses Breakdown by Apparatus

Apparatus / Station	01 - Jan	02 - Feb	03 - Mar	04 - Apr	05 - May	06 - Jun	07 - Jul	08 - Aug	Total
Station 11	487	432	445	503	512	539	569	463	3950
A311	248	211	216	256	243	208	269	227	1878
E311	161	149	156	164	203	213	187	172	1405
L311	78	72	73	83	66	118	113	64	667
Station 12	367	382	407	391	372	448	429	396	3192
A312	215	201	215	205	204	241	223	201	1705
B312	33	32	38	39	36	47	42	41	308
CAR312	13	18	12	12	13	11	3	9	91
E312	105	129	135	132	111	139	151	143	1045
WR312	1	2	7	3	8	10	10	2	43
Station 13	481	419	538	560	493	535	542	505	4073
A313	285	242	313	298	266	270	283	287	2244
A413	0	0	0	0	0	12	3	2	17
B313	40	37	36	48	52	51	64	59	387
E313	156	140	180	210	172	189	178	156	1381
E413	0	0	9	4	3	13	14	1	44
Station 14	193	159	189	145	199	195	207	213	1500
E314	178	144	182	141	188	187	198	198	1416
HM314	15	15	7	4	11	8	9	15	84
Station 15	84	90	115	106	109	145	132	137	918
E315	84	90	115	106	109	145	132	137	918
Station 16	143	133	179	148	158	167	164	155	1247
BR316	0	0	0	0	0	0	3	1	4
E316	143	127	174	148	158	155	154	154	1213
E416	0	6	5	0	0	12	7	0	30
Station 17	227	214	287	240	297	243	296	288	2092
A317	150	140	179	145	194	144	182	177	1311
BR317	0	0	1	2	1	0	2	4	10
E317	77	74	107	93	102	99	112	107	771
Total	1982	1829	2160	2093	2140	2272	2339	2157	16972



Governing Board Agenda Item

SUBJECT/TITLE: Resolution 2026-03 Authorization of Purchases From and Through the United States Government

STAFF CONTACT: Samantha Babich, Chief Administration Officer

SUMMARY STATEMENT:

Adopt a resolution authorizing Renton Regional Fire Authority to make purchases of supplies, materials, electronic data processing and telecommunication equipment, software, services, and/or equipment from or through the United States government without calling for bids, pursuant to RCW 39.32.090.

FISCAL IMPACT:

Expenditure N/A - enabling resolution

Revenue _____

Currently in the Budget Yes ☐ No ☐ N/A ☒

SUMMARY OF ACTION:

Staff are requesting Governance Board approval of a resolution formally authorizing the RFA to purchase supplies, materials, electronic data processing and telecommunication equipment, software, services, and/or equipment from or through the United States government without calling for bids, as permitted under RCW 39.32.090. This authorization allows the RFA to take advantage of federal purchasing contracts and pricing when doing so is in the best interest of the RFA, without the added administrative burden of a competitive bid process for each qualifying purchase. Individual purchases made under this authorization remain subject to the RFA's normal budget approval process.

Reviewed by Legal Yes ☒ No ☐ N/A ☐

EXHIBITS:

1. Resolution No. 2026-03 - Authorization of Purchases From and Through the United States Government

RFA GOVERNANCE BOARD RECOMMENDED ACTION:

I move to adopt Resolution No. 2026-03 authorizing Renton Regional Fire Authority to make purchases of supplies, materials, electronic data processing and telecommunication equipment, software, services, and/or equipment from or through the United States government without calling for bids, pursuant to RCW 39.32.090.

RENTON REGIONAL FIRE AUTHORITY

RESOLUTION NO. 2026-03

AUTHORIZATION OF PURCHASES FROM AND THROUGH
THE UNITED STATES GOVERNMENT

WHEREAS, RCW 39.32.090 authorizes the RFA to purchase supplies, materials, electronic data processing and telecommunication equipment, software, services, and/or equipment from or through the United States government without calling for bids when such authority is established by Resolution.

NOW THEREFORE, BE IT RESOLVED, that the Governance Board of Renton Regional Fire Authority hereby formally establishes and authorizes future purchases of supplies, materials, electronic data processing and telecommunication equipment, software, services, and/or equipment from or through the United States government without calling for bids when such purchases are in the best interest of the RFA.

ADOPTED by the Governance Board of Renton Regional Fire Authority at an open public meeting of such Board on the 14th day of September 2026, the following Board Members being present and voting:

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member



Governing Board Agenda Item

SUBJECT/TITLE: Resolution No. 2026-04 - Adoption of IAFF Health & Wellness Trust HRA Benefit Plan

STAFF CONTACT: Samantha Babich, Chief Administration Officer

SUMMARY STATEMENT:

Adopt a resolution transitioning RRFA's HRA benefit plan administration from BPAS to the IAFF Health & Wellness Trust (Gallagher HealthInvest), and approving the Adoption Agreement, SPD, and transfer of former plan assets.

FISCAL IMPACT:

Expenditure N/A Revenue N/A
Currently in the Budget Yes ☐ No ☐ N/A ☒

SUMMARY OF ACTION:

RRFA's current HRA benefit is administered by BPAS. This resolution approves moving administration to the IAFF Health & Wellness Trust, approves transferring existing plan assets to the new Trust, and authorizes the Fire Chief to execute the Adoption Agreement and routine future amendments without further Board action, unless funding obligations or benefit structure materially change.

Reviewed by Legal Yes ☒ No ☐ N/A ☐

EXHIBITS:

1. Resolution No. 2026-04
2. IAFF HRA Adoption Agreement (with Fee Sheet)
3. Summary Plan Description

RFA GOVERNANCE BOARD RECOMMENDED ACTION:

Move to adopt Resolution No. 2026-04, authorizing adoption of the IAFF Health & Wellness Trust HRA Benefit Plan and the transfer of former plan assets to the Trust.

**RENTON REGIONAL FIRE AUTHORITY
RESOLUTION NO. 2026-04**

**AUTHORIZING ADOPTION OF THE IAFF HEALTH & WELLNESS TRUST HEALTH REIMBURSEMENT
ARRANGEMENT (HRA) BENEFIT PLAN**

WHEREAS, Renton Regional Fire Authority (“RRFA” or the “Employer”) currently maintains a Voluntary Employees’ Beneficiary Association (VEBA) / Health Reimbursement Arrangement (HRA) benefit plan for the benefit of its eligible employees, previously administered by BPAS; and

WHEREAS, RRFA has determined it to be in the best interest of the agency and its employees to transition administration of the HRA benefit plan from BPAS to the IAFF Health & Wellness Trust, administered by Gallagher HealthInvest; and

WHEREAS, Section 2.1 of the IAFF Health & Wellness Trust HRA Adoption Agreement requires that the Employer, by formal action of its Governing Body or other authorized action, approve the establishment of the HRA benefit plan; and

WHEREAS, Section 5.1 of the IAFF Health & Wellness Trust HRA Adoption Agreement requires that the transfer of Former Plan Assets into the Trust be approved by the Employer, and that the officer or representative executing the Adoption Agreement be duly authorized and empowered to cause such transfer; and

WHEREAS, the Governance Board has reviewed the IAFF HRA Adoption Agreement and the Summary Plan Description presented, copies of which are attached hereto; and

WHEREAS, the Governance Board finds that adopting the IAFF HRA Benefit Plan and authorizing the transfer of former plan assets to the Trust will allow for the continued, uninterrupted provision of this benefit to RRFA employees;

NOW, THEREFORE, BE IT HEREBY RESOLVED,

That the form of the IAFF Health & Wellness Trust HRA Benefit Plan, including the HRA Adoption Agreement and Summary Plan Description presented at this meeting (a copy of which is attached hereto), is hereby approved and adopted; and

RESOLVED, that the transfer of former plan assets previously held under the BPAS-administered VEBA/HRA plan to the IAFF Health & Wellness Trust is hereby approved, and the proper agents of the Employer are authorized and directed to take all actions necessary to effectuate such transfer; and

RESOLVED, that the Fire Chief or designee is hereby authorized, on behalf of RRFA, to execute and deliver the HRA Adoption Agreement and any related plan documents necessary to adopt and implement the IAFF HRA Benefit Plan, and to execute future amendments, restatements, renewals, and related administrative agreements as may from time to time be necessary to maintain and administer the Plan on behalf of the Employer, without further action of the Governance Board unless such action would materially change the Employer's funding obligations or benefit structure; and

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify RRFA employees of the adoption of the Plan and to provide each eligible employee a copy of the Summary Plan Description.

ADOPTED by the Governance Board of Renton Regional Fire Authority, at an open public meeting of such Board on the 14th day of September, 2026, the following Board Members being present and voting:

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

IAFF Health & Wellness Trust Health Reimbursement Arrangement Adoption Agreement

Please complete the enclosed HRA Adoption Agreement in full for the Administrator to establish participant accounts. Once fully executed, a copy of this Agreement will be provided to you. For questions or assistance in completing this HRA Adoption Agreement, please contact Gallagher HealthInvest at 1-833-719-7197.

Plan Sponsor Information

The Board of Trustees of the IAFF Health & Wellness Trust is the Plan Sponsor of the health reimbursement (HRA) Plan you are adopting. The Plan Sponsor's mailing address and Tax Identification Number are as follows:

Board of Trustees of the IAFF Health & Wellness Trust
PO Box 3582
Seattle, WA 98124

Tax Identification Number: 46-1416156

INTRODUCTION

This HRA Adoption Agreement (the "Agreement") is executed below by an authorized representative of Renton Regional Fire Authority (the "Employer") for the purpose of formally adopting the IAFF Health & Wellness Trust Health Reimbursement Arrangement (the "HRA") Benefit Plan and the Plan Documents describing and setting forth the terms and conditions of the Plan. As part of the Employer's adoption of the HRA Benefit Plan, the Employer will also complete the IAFF Onboarding & Renewal Packet (the "Packet") to make plan design elections and provide the Plan with other important details for adoption and ongoing administration. By this Agreement and the Packet, the Employer applies for participation in the Plan and the Trust.

ARTICLE I General Provisions

1.1 Terms Incorporated by Reference; Conflicts with Defined Terms. Capitalized terms used herein and not defined herein shall have the meaning ascribed to such terms in the Plan Documents. In the event of a conflict in the definition ascribed to any term in more than one Plan Document, the conflict shall be resolved based upon the definition ascribed to the term in the document under which the provision in question references the term, and if not defined therein, then by reference to the definition ascribed to the term in the other Plan Documents in the following order: first by reference to most current Employer Packet, then to the applicable Component Plan Document, then to the Base Plan Document, then to this Plan Adoption Agreement, then to the Summary Plan Description, then to the applicable Enrollment File, and then to the Trust Agreement.

1.2 Construction and Interpretation of Plan Documents. Headings used in the Plan Documents are inserted for convenience of reference only and are not to be used in interpreting the provisions. Unless expressly noted otherwise, references to or definition of (1) any document, instrument, or agreement, (2) policy or procedure established, approved, or adopted by a party, or (3) any federal or state statute, regulation, administrative decision, ruling, rule, guidance, or order, shall mean the same as amended, restated, supplemented, or otherwise modified from time to time. The words "including," "includes," and "include" are used to mean without limitation. The word "or" is not exclusive. Wherever from the context it appears appropriate, each term stated in either the singular or plural shall include the singular and the plural, and pronouns stated for convenience in a specific gender (e.g., masculine, feminine, or neuter gender) are intended to include all genders.

ARTICLE II

Plan Adoption

2.1 Formal Authorization by Employer. The Employer, by formal action of its Governing Body or other authorized action, has formally approved the establishment of an employee benefit plan for the Employer's participating employees, pursuant to which the Employer will make contributions to one or more health reimbursement arrangement "HRA" plans (referred to herein individually and collectively as the "IAFF HRA Benefit Plan" or the "Plan") funded in the Trust established pursuant to the Trust Agreement. The Employer agrees to the engagement of certain service providers for the IAFF HRA Benefit Plan to assist the Employer in the administration of the Plan. The Employer shall be the party responsible for administering the Plan with respect to the eligibility and contributions for its respective employees ("Employees") and shall have adopted and become subject to the provisions of such Plan and the Trust.

2.2 Adoption of IAFF HRA Benefit Plan. Pursuant to the formal authorization of the Employer to adopt the Plan:

2.2.1 The Employer was provided a copy of the IAFF HRA Plan Documents as part of this adoption. The Employer hereby adopts the IAFF HRA Benefit Plan and the Plan Documents for the proprietary IAFF HRA Benefit Plan, including the further terms and conditions contained in this Agreement.

2.2.2 Collectively, the Plan Documents for the IAFF HRA Benefit Plan are all parts of a single, integrated employee benefit program and shall be construed together. The Base Plan Document and each of the Component Plan Documents adopted by this Agreement collectively set forth the terms and conditions for coverage that provides reimbursement of Qualified Health Care Expenses and Premium Expenses incurred by a Participant and Covered Dependents under the circumstances, and subject to the terms, conditions, and limitations set forth therein. The Plan Documents for the IAFF HRA Benefit Plan shall consist of and include the most current version of each of the following: (1) this Agreement, (2) the most current copy of the Employer's completed Packet, (3) the Base Plan Document, (4) each of the Component Plan Documents for Component Plans included in this IAFF HRA Benefit Plan, (5) the Summary Plan Description, (6) the Trust Agreement, and (7) with respect to a particular Participant, the individual Participant Enrollment File.

2.2.3 The execution of this Agreement shall constitute the execution by the Employer of the Plan Documents, including the Base Plan Document and each Component Plan Document. Any of the Plan Documents may be amended or amended and restated from time to time (each an "Amended Plan Document"), and unless the Employer rejects an Amended Plan Document in writing or terminates the Plan within 30 days of receipt of such Amended Plan Document, the Employer hereby agrees that it shall be deemed to have accepted, adopted, and executed the Amended Plan Document in accordance with its terms and effective date.

2.2.4 The Employer agrees it may utilize the Plan Documents only while the Plan Sponsor is engaged hereunder. Upon termination of this Agreement with the Plan Sponsor, the Employer shall no longer have the right to utilize the Plan Documents, and any use of the Plan Documents by the Employer after termination is subject to the Employer's indemnification obligations hereunder.

2.3 Specific Plan Terms Incorporated into Plan Documents. Specific terms and conditions with respect to the administration of the Plan and other information will be set forth in the Summary Plan Description for the Plan. These terms and conditions and other information ("Plan Information") may change or be amended from time to time at the discretion of the Plan Sponsor and includes, among other things, information about the Plan Sponsor, Administrator, Plan fiduciaries, and other information specific to the Plan Sponsor's Plan. The Plan Sponsor will ensure that accurate Plan Information is included in the Summary Plan Description and is updated as required to meet all applicable legal requirements for disclosure of Plan terms to eligible Employees and Participants and Covered Dependents under the Plan. The Plan Sponsor incorporates the Plan Information into the Plan and the

Plan Documents for all purposes, as initially set forth in the Summary Plan Description upon adoption of the Plan and as subsequently amended or restated from time to time.

ARTICLE III **Plan Design**

3.1 Onboarding and Renewal Packet (the “Packet”). The Packet is a summary of benefit and plan design elections and other Employer or Plan information completed by the Employer during initial adoption and onboarding. The Packet will be updated or amended and restated from time to time in connection with annual renewals of the Benefit Plans, annual service reviews, or as otherwise mutually agreed. Upon mutual completion of the Packet, the Plan will deliver the completed Packet to the Employer. The Packet will be deemed approved by the Employer upon approval by the Employer delivered electronically through the secure message feature, by email, or if the Employer has not otherwise rejected the completed Packet within ten (10) business days of delivery to the Plan.

3.2 Nondiscrimination; No Individual Choice. The Employer acknowledges, understands and agrees: (a) that its eligibility criteria and plan design will not discriminate in favor of highly compensated individuals in a manner prohibited by Internal Revenue Code Sections 105(h) or 501(c)(9); and (b) it will not permit Employees to make individual elections regarding Plan contributions that would violate applicable HRA plan guidance issued by the Internal Revenue Service or Treasury Department. In the event the IRS determines that (1) the Employer’s Plan design (as described in Schedule A) is discriminatory in favor of highly compensated individuals, or (2) the Employer permitted individual Employee elections, in either case resulting in taxable income to affected Employees or disqualification of the Plan or Trust, the Employer shall hold harmless and indemnify each Plan, Trust, Employer, and each of their respective trustees, fiduciaries, agents, officers, employees, successors, and assigns, for liability which may result therefrom;

3.3 Plan Design Selections. Pursuant to collective bargaining agreements, other written agreements, or Employer benefits policies, whichever is applicable, the Employer will elect plan designs per Employee group in the Packet, which is made a part of and incorporated herein this Agreement. Plan design options are as follows:

3.3.1 In-service Plan. Under the IAFF In-service HRA Benefit Plan (“In-service Plan”), the Plan pays benefits (subject to any vesting requirements) while the employee is actively employed and continuing after retirement or other separation from service from the Employer. The In-service Plan is designed to be an “integrated HRA Plan” in order to comply with exemptions from annual limits restrictions under Section 2711 of the Public Health Safety Act. The Employer acknowledges that the qualification of the In-service Plan as an integrated HRA Plan depends in part upon the Employer’s compliance with certain restrictions under applicable federal law. A Participant is eligible to receive contributions in the In-service Plan only if the Participant is (a) enrolled in the Employer’s qualified group health plan that provides “minimum value,” as defined by the Affordable Care Act regulations (a “Qualified Group Health Plan” or “QGHP”); or (b) eligible to enroll in the Employer’s QGHP but has certified or attested to the Employer that he or she is actually enrolled in another QGHP. If the Employer determines that any Participant is not eligible for contributions to the In-service Plan, applicable law requires that such contributions be directed to the Post-separation Plan described below in Section 3.3.2. A default Post-separation Plan account will automatically be established by the Administrator for all participants to accommodate those Employees that do not meet these integration requirements from time to time. The Employer shall hold harmless and indemnify each Plan, Trust, and each of their respective trustees, fiduciaries, agents, officers, employees, successors, and assigns, for liability which may result from the Employer’s making contributions on behalf of Participants who are neither enrolled in the Employer’s QGHP nor have certified in writing to the Employer that they are enrolled in a QGHP.

3.3.2 Post-separation Plan. Under the IAFF Post-separation Plan, the Plan pays benefits only after eligible Employees meet all vesting requirements and reimburses expenses incurred only after Employees retire or otherwise separate from service from the Employer.

3.3.3 Vesting. In the Packet, the Employer will elect whether certain groups or Plans are subject to vesting. If vesting applies, the Employer is responsible for tracking when an Employee becomes eligible to file claims after having met the Employer's vesting requirements and providing such notification to the Plan. Notification shall include what percentage of the Participant's account balance is vested (*e.g.*, 100% vested; 50% vested, 0% vested, etc.). Notification can be provided via the Employer's online employer portal or by submitting a Participant Status Change form. Any vesting requirements applicable to Participant Accounts must be satisfied before a Participant becomes eligible to file claims.

3.4 Plan Design Changes. Future changes to the Employer's Plan Design can be communicated to the Administrator at any time. Updates to Plan Design elections will be made upon the Employer completing and submitting a Plan Design Change form or completing an updated Packet. Such changes may include adding a new participating Employee group, a new funding method, changing existing funding methods, etc.

3.5 Forfeitures. In the event any funds within a Participant Account are forfeited in accordance with the terms of the Plan, such forfeited funds will be transferred to a temporary suspense account held within the Trust on behalf of the deceased or forfeiting Participant's Employer to be re-contributed as future contributions or otherwise applied for the benefit of all Participants of the Employer within the Trust, as directed by the Employer, but in all cases subject to applicable law, the terms of the Plan, and the rules, policies and procedures established by the Administrator.

3.6 Employer Account. In the Packet, the Employer can elect to establish an Employer Account that can be used to hold assets to offset other post-employment benefits, such as OPEB liabilities as defined by Governmental Accounting Standards Board Statement No. 75 (GASB 75) accounting rules. An Employer Account is not required in order to receive forfeitures as described in Section 3.5 above.

ARTICLE IV

Contributions and Investments

4.1 Contributions. The Employer acknowledges and agrees that it has the sole responsibility to make contributions to the Plan in accordance with whatever obligations, policies, or procedures have been established by the Employer (pursuant to collective bargaining or otherwise) and that neither the Trustees, the Administrator, the officers, employees or agents, or anyone acting on behalf of or with respect to the Plan and Trust has the right, duty, or power to determine the amount to be contributed to the Plan or collect the amount to be contributed. Rather, the Trustees' and Administrator's rights, duties, or powers arise and apply only with respect to contributions actually received by the Plan.

4.2 Allocation of Contributions. The Employer shall not make any contributions to the Plan without providing the Administrator with written direction as to how such contributions should be allocated. At the time any contribution is made to the Plan, the Employer shall direct the Administrator as to which Participant Account(s) the contribution is to be allocated by properly coding all contribution reports in accordance with the contribution instructions provided by the Administrator.

4.3 Investment Election of Participant Accounts. The Plan Sponsor shall determine the investment options into which the Participant Accounts may be invested. Each Employee shall elect one or more investment options and allocate funds to be invested in the applicable Participant Account. In the event an Employee makes no election of one or more investment options, such Employee's Participant Account or Accounts will be invested by the Administrator in one or more options whose investment objective is stable value.

4.4 No Guarantees. The Employer acknowledges and agrees that neither the Plan Sponsor, the Administrator, the Board of Trustees, nor any service provider acting hereunder guarantees that the Plan, Trust or any Participant Account or Employer Account thereof from loss or decline in value, or the payment of any amount which may become due to any person thereunder. Nothing contained in the Plan or Trust shall constitute a guarantee

by the Plan Sponsor, the Administrator, the Board of Trustees, or any service provider hereunder that the assets of the Plan and Trust will be sufficient to pay any benefit to any person or make any other payment; payments to be paid from the Plan are limited to the assets remaining in the applicable Participant Account or Employer Account at the time payment is made.

ARTICLE V

Transfers

The following Article V applies only to employers transitioning existing health reimbursement arrangement assets to the Trust for administration hereunder.

5.1 Employer Authorization for Former Plan Assets. The Employer has previously adopted and credited or made contributions into a health reimbursement arrangement (“HRA”) plan (and trust if applicable) as described in the Employer’s Packet (the “Former Plan”). Employer intends to transfer assets previously credited or contributed to the Former Plan (the “Former Plan Assets”) to the Trust and to amend and restate the Former Plan in the form of the Plan Documents. The Employer represents that the transfer of the Former Plan Assets into the Trust has been approved by the Employer and that the undersigned officer or representative of the Employer is duly authorized and empowered to cause the transfer of Former Plan Assets into the Trust. The Employer hereby directs the transfer of Former Plan Assets to the VEBA Trust in one or more transfers expected to occur on or around the transfer date memorialized in the Employer’s Packet, and that such transfer(s) are consistent with the provisions of the Internal Revenue Code and any other local, state, or federal law applicable to the Employer and the Former Plan.

5.2 Plan Feature Differences. The Employer acknowledges that the Plan may not have all or any of the same features and benefits as the Former. The Employer accepts full responsibility for communicating, and, prior to the date hereof has communicated, such differences to the participants covered by the Former Plan.

5.3 Participant Enrollment Required. The Employer understands that each of its participants covered by the Former Plan must first be enrolled as a condition of participation in the Plan. Former Plan Assets received on behalf of participants who have not been properly enrolled in the Plan will be held in a non-interest-bearing account for a period of three hundred and sixty (360) days, after which all remaining Former Plan Assets will be reallocated as directed by the Employer and as permitted under applicable law.

5.4 Default Investment of Former Plan Assets. The Employer understands that Former Plan Assets will be invested one hundred percent (100%) in the Plan’s default investment fund on behalf of Participants. Alternatively, the Employer may direct that Former Plan Assets be invested on behalf of Participants according to a mapping schedule as provided by the Trust’s investment consultant and approved by the Employer.

5.5 Transition Blackout; Former Plan Assets Automatic Premiums. The Employer understands that the Plan will work with the Former Plan’s administrator to determine the last day claims will be processed by the Former Plan and the first day claims will begin being processed by the Plan. The transition may require a blackout period in which claims, investments, and account updates will not be processed. Any active automatic premium reimbursements under the Former Plan will be cancelled and will not be transferred to the Plan.

5.6 Indemnification. To the extent permitted by law, the Employer agrees to indemnify and hold harmless the Trust and Plan and the trustees, fiduciaries, agents, officers, employees, successors, and assigns of each, against any and all claims, demands, damages, losses, liabilities, expenses or causes of action that arise out of, or are attendant to, the previous contribution of the Former Plan Assets into the Former Plan, the administration of the Former Plan or the Former Plan Assets under the Former Plan, or the transfer of such Former Plan Assets into the Trust

ARTICLE VI

General Provisions

6.1 HRA Benefit Plan Fees. Employer previously signed the IAFF Health & Wellness Trust Proposal's Fee Sheet (the "Fee Sheet") memorializing the applicable HRA Benefit Plan fees hereunder. Such Fee Sheet is incorporated into this Agreement and included as the Pricing Appendix attached hereto.

6.2 Termination. The Plan Sponsor may resign and terminate this Agreement at any time by giving notice in writing to the Employer at least one hundred-eighty (180) days before such resignation is to become effective, unless such notice period is waived by the Employer. The Employer may remove the Plan Sponsor and terminate this Agreement, with or without cause, by giving notice in writing to the Plan Sponsor at least ninety (90) days before such removal is to become effective, unless such notice period is waived by the Plan Sponsor. If the Plan Sponsor resigns or is removed for any reason, the Employer shall transfer all Plan assets pursuant to the provisions of Plan Documents prior to the effective date of such resignation or removal, unless a longer time period for transfer is agreed upon in writing between the Plan Sponsor and the Employer. The Plan Sponsor not be liable for the acts or omissions of any successor Administrator or service provider providing one or more similar services to the Plan as provided by the Plan Sponsor.

6.3 Indemnification.

6.3.1 Employer Indemnification. The Employer agrees, to the fullest extent permitted by applicable law, to indemnify and hold harmless the Plan Sponsor, the Board of Trustees, and the Administrator, and other service providers against all costs, expenses, liabilities and damages resulting from any misrepresentation, negligent action or inaction, or breach of this Agreement, the Plan, the Trust or any rules, policies or procedures established by the Administrator, on the part of the Employer or its officers, employees or agents acting in such capacity on behalf of the Employer. Neither Plan Sponsor, Administrator, Board of Trustees and other service providers retained by the Administrator nor their affiliates, successors or assigns shall have any liability, duty or other obligation with respect to actions or omissions (including incomplete or incorrect data provided by the Employer or Participants) of the Employer or of any successor or predecessor trustee, custodian, or other investment or service provider.

6.3.2 Plan Sponsor Indemnification. The Plan Sponsor agrees, to the fullest extent permitted by applicable law, to indemnify and hold harmless the Employer against all costs, expenses, liabilities and damages resulting from any misrepresentation, negligent action or inaction, or breach of this Agreement, the Plan, the Trust or any rules, policies or procedures established by the Administrator, on the part of the Plan Sponsor, Administrator, or the Board of Trustees, or any of their officers, employees or agents, acting in such capacity on behalf of the Plan Sponsor, Administrator or Board of Trustees. The Employer shall have no liability, duty or other obligation with respect to actions or omissions of the Plan Sponsor, Administrator, Board of Trustees and other service providers retained by the Administrator.

6.4 Notices. Any notice required or permitted under this Agreement or the Plan Documents shall be in writing and shall be deemed delivered when deposited in the United States mail, postage prepaid, certified mail, return receipt requested, addressed to the respective parties at the addresses set forth below.

6.4.1 Employer Address. The address for delivery of all communications to the Employer are set forth in the most recently completed Packet.

6.4.2 Plan Sponsor Address. The address for delivery of all communications to the Plan Sponsor shall is set forth on the first page of this Agreement.

6.5 Prior or Contemporaneous Agreements. This Agreement supersedes all prior or contemporaneous agreements or understandings regarding the matters pertaining hereto, whether oral or written,

that are not specifically referenced and made a part of this Agreement. This Agreement may be amended only in writing, and no purported oral agreement or understanding, or conduct or course of conduct, will be binding on any party hereto, unless reduced to writing and executed by authorized officers of all parties hereto.

The remainder of this page is intentionally left blank.

IN WITNESS WHEREOF, the Employer has approved this Agreement and accepts the terms herein, as of the 14th day of Sept, 2026 (the “Effective Date”) as evidenced by the signature below of its authorized officer.

EMPLOYER
Renton Regional Fire Authority

By: _____

Name: Steven C. Heitman

Title: Fire Chief

Date: September 14, 2026

Accepted By:
PLAN SPONSOR
IAFF Health & Wellness Trust

By: _____

Name: Greg Markley

Title: Trust Chair

Date: _____

HRA/FSA Fee Sheet



Renton Regional Fire Authority

5/6/2026

Employer/Plan Sponsor Name

Date

Service Summary: Customer Care Center; education and communication; plan administration; debit card; technology and security; recordkeeping; investments (as applicable); banking, custodial, and trustee services (as applicable); consulting and compliance services, plan document; reporting; etc.

	☒ HRA ^{1, 2}	☒ FSA ¹
Monthly Fee (Third-party) Per participant fee deducted from participant accounts or billed to employer/plan sponsor once per calendar month. If the total amount of this fee across all participants is less than \$100 for a single product in any given month, the difference up to a maximum of \$100 will be billed to the employer/plan sponsor.	\$3.50	Waived
Asset-based Fee (Third-party) Prorated and charged to each participant's account as a reduction to daily investment earnings or losses (1/365).	35 bps	Waived
Monthly Fee (IAFF Trust Administration) Per participant fee deducted from participant accounts or billed to employer/plan sponsor once per calendar month.	\$0.50	N/A
Setup Fee Billed to the employer/plan sponsor at plan adoption.	Waived	Waived
Annual Fee Billed to the employer/plan sponsor beginning in year two.	Waived	Waived
Termination/Transfer Fee Billed to employer/plan sponsor at termination or transfer.	Waived	Waived

¹ **Patient-Centered Outcomes Research Institute (PCORI) Fee** (required for HRAs not integrated with the employer's/plan sponsor's group health plan; may be required for FSAs if not an excepted benefit under federal health care reform regulations): If applicable, applies to claims active accounts only. This federal fee (tax) is adjusted annually and payable by IAFF Health & Wellness Trust. PCORI fee calculation assistance is available. ² **Fund Expenses** (for HRAs): Fund operating expenses (expense ratios), which may include 12b-1 fees as indirect compensation for plan recordkeeping services, vary by fund and are applied at the fund level.

IMPORTANT: The fees listed above cover the entire scope of services for the quoted product(s). Quote is valid for 30 days and is based on IAFF Health & Wellness Trust's understanding of the employer's/plan sponsor's program. Material differences, such as number of participants, total assets, or claims eligibility, that become known or occur before or after official plan adoption may necessitate a fee adjustment. Amounts, if any, invoiced to the employer/plan sponsor are due and payable within 30 days.

Authorization

By signing below, I certify that I am authorized to accept and approve these fees on behalf of the above-named employer/plan sponsor.

Samantha Babich

Digitally signed by Samantha Babich
Date: 2026.05.06 13:21:36 -07'00'

Authorized Signature

Samantha Babich

Printed Name

05/06/2026

Date

Chief Administration Officer

Title

Please return a signed copy of this Fee Sheet within 30 days.

Acceptance of this Fee Sheet and a fully executed Employer Adoption Packet for each desired product is required to officially facilitate a plan transfer (if applicable) and schedule a go-live date.

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Summary Plan Description

July 2026



IAFF Health & Wellness Trust

Welcome! You are an eligible participant in the **IAFF Health & Wellness Trust HRA Plan ("Plan")**. Please carefully review this Summary Plan Description (SPD) regarding your health reimbursement arrangement (HRA) and keep it in a safe place for future reference.

HRA Dashboard. The HRA Dashboard included with your welcome packet, which was mailed to you upon enrollment, contains important Plan and account information, your coverage type, claims-eligibility, and investment allocation. If you misplace your welcome packet, you can request a replacement copy from our Customer Care Center (see contact information below).

Investment Allocation. Your account is invested 100% in the default investment option or as otherwise directed by your employer until you make a change.

Online Registration. To help protect your account, you should register online and create a password. Go to **IAFFHealthTrustHRA.com**, click the **Participant Login** button, and follow the instructions. After logging in, you can check and update your **investment allocation**, add your **spouse and dependent information**, set up **direct deposit** for claims, and elect **e-communication**.

Mobile App. Managing and using your HRA has never been easier. After registering online, search and download our handy mobile app, **HRAgo®**, from the App Store or Google Play.

Submitting Claims. When you're ready to file a claim, log in at **IAFFHealthTrustHRA.com** and click **Claims**, or use **HRAgo**. With **HRAgo**, you can quickly snap pics of supporting documentation and submit claims right from your mobile device. We'll process your claim in about five to seven business days.

Debit Card. You can use your free debit card to pay for medical expenses directly from your HRA. No filing claims and waiting to get reimbursed! Be sure to save all supporting documentation (insurance Explanations of Benefits (EOBs, itemized statements, etc.) in case we need copies.

Automatic Premium Reimbursements. We can automatically reimburse your monthly retiree insurance premiums, including Medicare. Log in at **IAFFHealthTrustHRA.com** and click **Claims**. Then, click the **Set up an Automatic Premium Reimbursement** button and follow the instructions.

This SPD explains how to use your Plan benefits and the rights and responsibilities of those covered by the Plan. You and all covered individuals should read and become familiar with its content. In the event of a discrepancy between this SPD and the actual Plan and Trust documents, the Plan and Trust documents control. Other than the Plan and Trust documents, this SPD supersedes any previously published Plan informational materials. This SPD will be amended from time to time. For the most current version, log in at **IAFFHealthTrustHRA.com** and click **Resources**, or contact our Customer Care Center (see contact information below).

Group health plans are required to furnish a standardized **Summary of Benefits and Coverage (SBC)** annually. The purpose of the SBC is to help consumers compare benefits across available insurance plans. While the Plan is a group health plan, it is not insurance. Therefore, certain information and defined terms in the SBC do not apply. This **Summary Plan Description** is your best source for detailed Plan information. If you need a copy of the SBC, log in at **IAFFHealthTrustHRA.com** and click **Resources**. Printed copies are available upon request from our Customer Care Center (see contact information below).

Your employer or plan sponsor may not have elected to include all of the benefits or plan features described in this SPD. Your welcome packet confirms your benefits eligibility and any limitations. You can also find this information after logging in at **IAFFHealthTrustHRA.com**.

The most current SPD supersedes any previously published Plan informational materials. **By participating in the Plan, you agree to the Terms & Conditions set forth within Part X of this SPD.**

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QUESTIONS?

Customer Care Center PO Box 4390
Clinton, IA 52733-4390

1-833-719-7197



Part I

Plan Information

The name of the Plan is: IAFF Health & Wellness Trust HRA Plan ("Plan"). The plan year is the 12-month period from January 1 through December 31. IAFF Health & Wellness Trust is the plan sponsor and administrator for your Plan. Contact IAFF Health & Wellness Trust if you need more information. Your welcome packet contains plan sponsor contact information.

Plan assets are held in a custodial account and trust established by Alta Trust Company, who serves as the HRA Master Trustee, a non-discretionary, directed trustee.

HealthInvest HRA Master Trustee

Alta Trust Company
9380 Station Street, Suite 450 Lone Tree, CO 80124
PH: 1-866-516-4015

The Trust is otherwise governed by a Board of Trustees who serve as fiduciaries for your Plan.

IAFF Health & Wellness Trust Board of Trustees

PO Box 3582
Seattle, WA 98124

Custodial and transfer agent services are provided by Charles Schwab Trust Bank. Daily banking services are provided by Washington Trust Bank headquartered in Spokane, WA.

Plan administration support services, including claims processing, are provided by Gallagher Benefit Services, Inc., the HRA Service Manager, or its designees, at the direction of the plan administrator.

HRA Service Manager

Gallagher Benefit Services, Inc.
221 N Wall Street, Suite 201
Spokane, WA 99201

Service of legal process may be made to the plan sponsor and administrator at the address below.

HRA Plan Sponsor and Administrator

IAFF Health & Wellness Trust
PO Box 3582
Seattle, WA 98124

This Plan is a welfare benefit plan that provides medical benefits only. This Plan does not provide retirement income. The medical reimbursement benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf. Accordingly, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

Eligibility and funding sources are usually defined in writing within wrap plan documents, wrap SPDs, collective bargaining agreements, employer policies, or other similar documentation. Contact your employer, union, or employee group leadership if

you have questions about your HRA participation or need a copy of the collective bargaining agreement or employer policy.

Requests for benefits under the Plan must be made in writing in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing.

This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Refer to Appendix A (ERISA Supplement) containing additional information regarding your Plan and your rights under the Plan as required by ERISA. You may also receive a Summary of Material Modifications (SMM) from time to time to provide you with timely notice of certain material changes to the Plan or information required to be included in this SPD or any wrap SPD. **You should read this SPD (as updated from time to time), any SMMs, any wrap SPD, your welcome packet, and Appendix A, together to fully understand your benefits and your rights under the Plan.** To get the most current version, log in at and click **Resources**.

The plan administrator has the right to interpret the provisions of this Plan and make decisions on behalf of the Plan. Benefits under this Plan will be paid only when the plan administrator decides, in its discretion, that the participant or covered individual is entitled to benefits in accordance with the terms of the Plan. In the event a claim for benefits has been denied, no lawsuit or other action against the Plan may be filed until the matter has been submitted for review under the ERISA-mandated review procedures contained in Appendix A of this SPD. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

Part II

Questions & Answers

What is an HRA? An HRA or health reimbursement arrangement is a type of welfare benefit plan or group health plan. An HRA is generally funded by the employer (or through mandatory group funding) and reimburses employees (participants) for qualified out-of-pocket medical care expenses and insurance premiums incurred by the employee, the employee's spouse, and qualified dependents. To understand who qualifies as a dependent, see **Part III** for our **Definition of Dependent** information.

What is a "funded" HRA? A funded HRA is designed so that your employer contributes funds into an individual account on your behalf. Common funding methods include unused leave cash-outs (annually, at separation, or retirement), mandatory employee contributions (group salary reduction), direct employer contributions, and excess or leftover benefit dollars. Eligibility and funding sources, including any changes in funding, are usually defined in writing within collective bargaining agreements, employer policies, or similar documentation. Check with your plan sponsor, employer, union, or employee group leadership if

you have questions about what HRA funding sources may apply to you.

IAFF Health & Wellness Trust has been established for the safekeeping of your HRA funds. Funds for all plans and trusts participating in the Plan are contributed to a custodial account and master trust established by Alta Trust Company, who serves as the HRA Master Trustee, a non-discretionary, directed trustee.

All contributions, investment earnings, and reimbursements (benefit payments) are tax-free. Contributions to your HRA are not subject to federal income tax or FICA tax. Investment earnings credited to your HRA are not subject to federal income tax.

Reimbursements paid out as qualified medical expenses on behalf of participants, spouses, and qualified dependents are also excluded from tax. HRA contributions will not be reported on IRS Form W-2 from your employer. You do not report HRA contributions, earnings, or benefit payments (reimbursements) on your individual IRS Form 1040 federal income tax return either.

Who is the plan sponsor for my Plan? IAFF Health & Wellness Trust is the plan sponsor.

What type(s) of benefits coverage do I have? Based upon current guidance issued under federal law, the HealthInvest HRA offers three different types of benefits coverage: **In-service Benefits coverage**, **Post-separation Benefits coverage**, and **Limited HRA coverage**. Each of these plan coverages is designed to be exempt from the annual and lifetime dollar-limit restrictions for group health plans. This means that your benefits under the Plan are limited by your account balance at the time you file any claim for reimbursement of qualified medical care expenses.

Some employers or plan sponsors may establish and contribute funds on your behalf to more than one HRA, and each account may provide a different coverage type. Your **welcome packet** confirms your benefits coverage type at the time of enrollment. However, your coverage could change based upon restrictions under applicable law or coverage election changes that you make. You can always log in at to confirm your current benefits coverage for each account.

What is In-service Benefits coverage? In-service Benefits coverage is designed to be “integrated” with each employer’s qualified group health plan that complies with certain requirements under federal law. Under the terms of the In-service Benefits Plan document, a participant’s HRA is considered integrated with the employer’s qualified group health plan and eligible to receive employer contributions only if, at the time the participant becomes eligible for such contribution, the participant is eligible to enroll in his or her employer’s qualified group health plan and either (a) is actually enrolled in or covered by the employer’s qualified group health plan or (b) has provided written confirmation of enrollment in or coverage under another qualified group health plan. Read our **What is a Qualified Group Health Plan?** handout to learn more. To get a copy, log in at and click **Resources**, or contact

our Customer Care Center (see front page).

Please note that HRAs of participants who are offered coverage through the purchase of individual policies (as opposed to employer-sponsored group coverage) are not considered integrated with the employer’s qualified group health plan and are not eligible to receive contributions to an account that allows In-service Benefits.

What is Post-separation Benefits coverage? Post-separation Benefits coverage is designed to provide benefits only after a participant separates from service or retires. Post-separation (retiree-only) HRAs are not subject to the annual and lifetime limits restrictions and certain other provisions of federal law. The Plan can accept contributions into an account limited to Post-separation Benefits on behalf of any eligible employee, including those who are not eligible to receive contributions to an In-service Benefits account.

What is Limited HRA coverage? Limited HRA coverage is designed to provide limited forms of benefit coverage based upon plan design elections by your plan sponsor, restrictions governed by federal law, or certain elections made by you as further described below. For information about Limited HRA coverage based upon plan design or restrictions governed by federal law, read **Are there any restrictions?** below. For more information about Limited HRA coverage based upon elections made by you, read **What is Limited HRA coverage, and why might I need it?** below.

Where can I find the forms I will need for my HRA plan? All the HRA forms that you will need in order to file claims, change investment allocations, change personal information, and make other elections can be obtained by logging in at **IAFFHealthTrustHRA.com** or upon request from our Customer Care Center (see front page).

When and how can I get money out of my HRA? For HRAs with In-service Benefits, employees may file claims while they are currently employed (in-service) for expenses they incur after they are enrolled. HRAs limited to Post-separation Benefits require employees to separate from service or retire (and, in some cases, satisfy employer vesting requirements) before becoming eligible to file claims for expenses incurred after separation from service.

You can confirm your claims eligibility and any vesting requirements by referencing your **welcome packet** or by logging in at **IAFFHealthTrustHRA.com**. If you are not immediately eligible to file claims, you will be notified when you do become eligible. After becoming claims-eligible, and depending on the eligibility terms of your HRA, you may begin filing claims for qualified out-of-pocket medical care expenses incurred by you, your spouse, and any qualified dependents.

You may file claims for any amount, but reimbursements are limited to your available HRA balance. Eligible benefits will be paid until your HRA is exhausted. Your employer’s plan design, IRS rules, or certain elections made by you may limit dependent coverage, as well as when and what expenses may be reimbursed.

Claims payment is efficient and hassle-free. You can submit claims, sign up for direct deposit, or set up automatic reimbursement of recurring qualified insurance premiums after logging in at IAFFHealthTrustHRA.com. If you prefer, you can use paper forms instead. Paper forms are available after logging in online or upon request from our Customer Care Center (see front page).

What expenses are eligible for reimbursement? Eligible expenses generally include qualified medical, dental, and vision expenses (not covered by your insurance plans) and premiums for medical, dental, or vision, insurance or for Medicare premiums and expenses, and tax-qualified long-term care insurance. Eligible expenses are defined in Internal Revenue Code § 213(d). For a list of common qualified expenses and premiums, read our **Medical Care Expenses** handout available after logging in at IAFFHealthTrustHRA.com or upon request from our Customer Care Center (see front page).

IRS regulations provide that insurance premiums may not be reimbursed by your Plan if they are (1) paid by an employer, (2) eligible to be deducted through your employer's Section 125 cafeteria plan, or (3) subsidized by the Premium Tax Credit (subsidy). When requesting reimbursement of premiums deducted from your paycheck after tax, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available to you. Qualified premiums deducted from your spouse's paycheck after tax are eligible for reimbursement regardless of whether a pre-tax option exists for your spouse.

Qualified expenses that may be reimbursed from your HRA for you and your dependents will depend on the applicable plan design, IRS rules, or certain elections you may make to limit your HRA coverage. For example, some plan designs limit reimbursements to qualified insurance premiums only. Under certain circumstances (discussed later in this Section), expenses for your spouse and dependents may be limited based upon rules imposed under federal law. Also, if you have elected Limited HRA coverage (discussed later in this Section), the types of expenses eligible for reimbursement are limited.

Are there any restrictions? Reimbursements (claims) may never exceed your available account balance at the time you file the claim. Depending on the applicable plan design, your account may be subject to vesting requirements or be limited to Post-separation Benefits coverage. Also, some employers or plan sponsors limit reimbursements to qualified insurance premiums only. Some employers or plan sponsors may establish and contribute funds on your behalf to more than one type of HRA, and each account may be subject to different limitations as further described in this Section. Your **welcome packet** confirms your benefits eligibility and any restrictions on your account. You may also log in at IAFFHealthTrustHRA.com to confirm whether your Plan has any limitations on reimbursable expenses.

If your plan sponsor has established an HRA for you that is limited to Post-separation Benefits coverage, IRS rules require that your claims eligibility be limited to reimbursement of expenses and premiums for dental, vision, and qualified

long-term care ("Excepted Benefits") during any period that you are subsequently re-employed with the employer that made contributions to your HRA. For some Post-separation Benefits plans, the HRA plan design may permit reimbursement for Excepted Benefits during active employment, while other employer Post-separation Benefits plans may not.

If you have an In-service Benefits HRA (meaning your account permits In-service Benefits coverage), spouse and dependent integration rules issued under federal law will apply. This means that certain expenses for your spouse and dependents may not be reimbursable while you are employed, unless your spouse and dependents are covered under a group health plan (GHP) at the time the expense is incurred. The spouse and dependent integration rules **only** apply if you are still working for the employer who contributed to your account.

You can confirm GHP coverage for your spouse or dependent(s) on your claim form when you submit a claim. If your spouse or dependent(s) are not covered by a GHP, you can still use your HRA to reimburse you for their dental expenses and premiums, vision expenses and premiums, and tax-qualified long-term care expenses and premiums.

Can my HRA automatically reimburse qualified insurance premiums? Yes. Simply submit a completed and signed **Automatic Premium Reimbursement** form with proper documentation. Based on your instructions, the Plan will reimburse qualified insurance premiums from your account on an automatic basis. Direct deposit of reimbursements is available and recommended.

What happens if my claim for reimbursement is denied or paid in error? If your claim for reimbursement of expenses is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims are discussed in Part IV of this document or in any applicable wrap SPD.

If after receiving a reimbursement it is later determined that you, your spouse, or a qualified dependent received a payment in error, federal regulations require that you repay the overpayment or erroneous reimbursement back to your IAFF HRA. If you do not repay the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment against your account.

What is Limited HRA coverage, and why might I need it? Limited HRA coverage is an election that limits the types of expenses and premiums that are eligible for reimbursement from your HRA. If your HRA is fully claims eligible, you may want or need to limit your HRA if: (1) you are a current employee and you, your spouse, or a dependent have Medicare coverage that you want to be primary to your HRA coverage; (2) you, your spouse, or a dependent would like to be eligible to make or receive contributions to a health savings account (HSA); or (3) you, your spouse, or a dependent want to become eligible to receive a Premium Tax Credit (subsidy) through a marketplace exchange.

HSA Coordination. IRS rules allow you to have an HRA and an HSA, though certain restrictions apply. If you are claims-eligible, you can use either your HRA or HSA to reimburse your qualified expenses (there are no ordering rules regarding which account must pay first). However, if you have a claims-eligible HRA, current IRS rules require that you limit that HRA coverage if you want to make or receive contributions to an HSA. Keep in mind that limiting your HRA is not the only HSA contribution eligibility requirement. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for HSA coordination purposes: dental (including orthodontia); qualified high-deductible health plan (HDHP) premiums; and vision.

Medicare Coordination. If you have a claims-eligible HRA and are still working for your contributing employer, Medicare Coordination of Benefits rules may require your HRA pay first. If you are retired or separated from your HRA contributing employer, the Medicare Coordination of Benefits rules will **not** apply to your HRA. Read Part VII for more information about your HRA and Medicare. If Medicare Coordination of Benefits rules do apply to your HRA, you may limit your HRA until you separate from service so that Medicare instead pays first. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Medicare coordination purposes: dental (including orthodontia); vision; and Medicare and Medicare supplement premiums.

Premium Tax Credit Eligibility. For any month that you are claims-eligible and have a positive account balance in your HRA, you may not qualify for the Premium Tax Credit (subsidy) unless you take certain action. Please refer to Part VI for more information. Only the following types of expenses and premiums are eligible for reimbursement while your HRA is limited for Premium Tax Credit eligibility purposes: dental (including orthodontia); qualified long-term care (subject to IRS limits); and vision.

To elect Limited HRA coverage, simply submit a completed **Limited HRA Coverage Election** form. Forms are available online after logging in at IAFFHealthTrustHRA.com or upon request from our Customer Care Center (see front page).

What happens if I get divorced? In the event that you become divorced or legally separated, your account may be split as part of a divorce decree, court order, or similar agreement. Coverage for an ex-spouse is taxable. Contact the Customer Care Center for more information.

What if I pass away before I use up my HRA? Generally, if you pass away with a vested, positive account balance and you are survived by a spouse or qualified dependents who are covered under your HRA plan, your spouse (which may include registered domestic partners, if recognized as legal spouses under state law) and/or dependents (or their guardians) may submit claims for medical expense reimbursements until your account is exhausted. In the unlikely event you pass away with an unused account balance and have no eligible survivors, the executor of your estate can spend down your account by filing claims for any unreimbursed medical care expenses you may have incurred prior to your death.

Remaining funds (if any) after all final claims have been reimbursed would then be forfeited and re-contributed per the terms of the Plan document or otherwise applied as directed by your plan sponsor or employer. As a general rule, IRS rules do not permit the payment of benefits to non-dependent heirs or beneficiaries under your Plan.

Are there any other forfeiture provisions? Yes, a claims-eligible HRA may be forfeited and redistributed according to instructions from your plan sponsor. A forfeiture would apply if, during a period equal to the lesser of the applicable unclaimed property period or three years: (1) at least two communications from the Plan to the participant have been returned as undeliverable; (2) there have been no contributions to or reimbursements (claims) from the participant account; and (3) no communications or other expressions of interest have been received from or on behalf of the participant.

Is my HRA vested? That depends upon your employer's policy or collective bargaining agreement, whichever is applicable. Some HRAs limited to Post-separation Benefits may be subject to vesting requirements of your employer. Your **welcome packet** for each HRA established for you confirms whether vesting requirements apply to your account. You can also check with your employer or plan sponsor to confirm whether one or more of your HRAs are subject to vesting.

If your HRA is subject to vesting, your employer or plan sponsor will notify the Plan when you separate from service and confirm whether you are partially or fully vested. The Plan will then notify you of your vested amount that is available to reimburse claims for qualified expenses.

How are my HRA funds invested? You may invest your HRA using any combination of the available investment funds. You may change your investment allocation as often as once per calendar month after logging in at IAFFHealthTrustHRA.com or by calling our Customer Care Center (see front page).

An **Investment Fund Overview** with investment performance history and fund objectives is updated quarterly and available after logging in at IAFFHealthTrustHRA.com. In addition, you may view and should read the up-to-date fund fact sheets and prospectuses on the fund websites, which are listed on the Investment Fund Overview.

Will I receive a statement of my account? Yes. Participant account statements, which detail all of your account activity, are updated quarterly and available for viewing online after logging in at IAFFHealthTrustHRA.com. If you are signed up for e-communication, you will receive quarterly email notifications as soon as your statements are available for online viewing. If you are not signed up for e-communication, paper statements will be mailed quarterly to your address on file. You may contact our Customer Care Center (see front page) to request copies of your statements at any time.

Can I view my account information online? Yes. You may view your personal account information online after logging in at. Information available online includes account details and preferences, investment performance, contribution and claims history, and participant forms. You can also set up an

automatic premium reimbursement, update account preferences, and update your personal information (name, address, etc.).

Are any fees or expenses deducted from my HRA? A flat monthly account fee and an annualized asset-based fee is deducted from your account. Fees deducted from your account are listed on your account statements under **Important Notes**. It is possible that these fees could exceed your investment return.

Plan expenses include costs for plan administration services, including enrollment and claims processing, plan management, recordkeeping, legal, compliance, printing, banking and custodial, web management, investment management, postage, etc. These Plan expenses are paid from Plan administrative fees.

Investment fund manager fees and other fund expenses are based on the investment fund(s) you select. To view these fees, refer to the **Investment Fund Overview** for your employer's plan. You can get a list of fees applicable to your Plan and a copy of the Investment Fund Overview online after logging in at **IAFFHealthTrustHRA.com** and clicking **Resources**.

Will the Plan always be available? Your plan sponsor retains the right to discontinue your Plan subject to the provisions of collective bargaining (if applicable), ERISA, and in accordance with the terms of your Plan's trust instrument. If the Plan were to be discontinued, Plan assets would be treated in accordance with the terms of the Plan document and the terms of your Plan's trust instrument.

Part III Definition of Dependent

Your spouse and dependents are eligible for coverage under your health reimbursement arrangement (HRA). Dependents must meet the definition of Qualifying Child or Qualifying Relative. These requirements are defined by Internal Revenue Code Sections 105(b) and 152.

A **Qualifying Child** is someone who: (1) is the participant's son or daughter, stepchild, foster child; and is a citizen, national, or resident of the United States or a resident of Canada or Mexico; and is either (a) age 26 or younger at the end of the calendar year in which expenses were incurred, or (b) permanently and totally disabled; or (2) is a brother, sister, stepbrother, stepsister, or a descendant of the participant's son, daughter, stepchild, or foster child; and is either (a) under age 19, or (b) under age 24 and a full-time student, or (c) permanently and totally disabled; and is younger than the participant; and lives with the participant for more than half the year; and does not provide more than half of his or her own support; and will not file a joint tax return for the year in which the expense was incurred; and is a citizen, national, or resident of the United States or a resident of Canada or Mexico.

A **Qualifying Relative** is someone who: (1) is the participant's

(a) son, daughter, stepchild, foster child, or a descendant of any of them (e.g. a grandchild); or (b) brother, sister, or a son or daughter of either of them; or (c) father, mother, or an ancestor or sibling of either of them (e.g. the participant's grandmother, grandfather, aunt, or uncle); or (d) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or (e) any other person (other than the participant's spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and (2) will not be a Qualifying Child or any other person as of the last day of the calendar year in which expenses were incurred; and (3) for whom the participant provided over half the support for the calendar year; and (4) is a citizen, national, or resident of the United States or a resident of Canada or Mexico.

Qualifying Child of Divorced or Separated Parents. A participant's child is treated as the dependent of both parents for the purposes of health plan coverage if during the calendar year in which expenses were incurred: (1) the participant's child is in the custody of the participant or their other parent for more than half the year; (2) the participant's child receives over half of his or her support during the year from the participant or their other parent.

Domestic Partners. Unless your domestic partner qualifies as a legal spouse under state law, a domestic partner must meet all of the **Qualifying Relative** requirements to be eligible for coverage under your HRA. If you need to list your domestic partner as a dependent, please give us a call.

Part IV Procedure for Disputed Claims

The following is an overview of how you may dispute denied claims. These procedures shall apply unless disputed claims procedures are otherwise provided for in a wrap SPD. Be sure to read this SPD and any wrap SPD together to understand how to address any disputed claims.

If you have a question or complaint regarding how one of your claims was adjudicated, please reach out to our Customer Care Center (see front page). A Customer Service Representative will be happy to look into your claim and address your questions or concerns. Our Customer Care Center is often able to help resolve the matter and alleviate any frustrations.

When must I receive a decision on my claim? You are entitled to notification of the decision on your claim within 30 days after the Plan's receipt of the claim. The 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Plan. The Plan is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Plan will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the

additional information. If you submit the additional information, the Plan will notify you of the decision on your claim within 15 days after the date of receipt of such information. If you do not submit the additional information, the claim will be deemed to be denied immediately following such 45-day period. The notice from the Plan requesting additional information may also contain a provisional denial of the claim in the event the additional information is not received within the 45-day period.

What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Plan will include the following information: (1) the specific reason or reasons for the denial and sufficient information to identify the claim involved, if any, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) specific references to pertinent plan provisions or IRS rules and regulations on which the denial is based; (3) an explanation of your right to appeal the denial; (4) a description of any additional material or information necessary for you to perfect the claim or appeal the denial and an explanation of why such material or information is necessary; (5) an explanation of your right to review the claim file and to present additional evidence, comments, or testimony as part of the appeals process; (6) a description of available internal appeals procedures, including information regarding how to request an internal review of your denial and the time frame within which to submit such a request; and (7) an explanation of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist with the internal claims and appeals and external review procedures.

If you do not receive an approval or denial of your claim within the initial time period for review of your claim, your claim will be deemed to have been denied.

Do I have the right to appeal a denied claim? Yes, you have the right to an internal appeal and, if applicable, an external review by an independent review organization.

Do I have to appeal a denied claim before I can go to court? You will not be allowed to take legal action against the Plan, your employer or plan sponsor, the administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit, and a final external review decision does not prevent you from pursuing other state or federal law remedies if they are available.

Is there a deadline for requesting my internal appeal? Yes. Your internal appeal must be delivered to the Plan within 180 days from the date you receive notice that your claim was denied or from the date your claim was deemed to be denied. If you do not file your internal appeal within this 180-day period, you lose your right to appeal.

How will my internal appeal be reviewed? Any time before the deadline to request an internal appeal, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Plan. The Plan is

required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Plan will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Plan relies on, generates, or considers new or additional evidence in connection with its final internal adverse benefit determination, other than evidence that you have provided to it, you will be provided with this information within 30 days after the date the Plan received your request for internal appeal, and given a reasonable opportunity (15 days) to respond to the evidence or rationale before the due date for the Plan's internal review decision. If you do not respond to the new or additional evidence or rationale considered in denying your claim within the time period permitted to respond, your claim will be deemed to have received a final internal adverse benefit determination immediately following such time period. The notice from the Plan with such additional evidence or rationale may also contain a provisional final internal adverse claim determination in the event the additional information is not received within the specified time period.

The internal appeal determination will be conducted by someone who is not (1) the individual who made the original determination; or (2) an individual who is a subordinate of the individual who made the initial determination.

When will I be notified of the decision on my internal appeal? The Plan must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

What information is included in the notice of the denial of my internal appeal? If you receive a final internal adverse benefit determination, the notice that you receive from the Plan will include the following information: (1) the specific reasons for its decision and sufficient information to identify the claim involved, including the date of service, the healthcare provider, and the claim amount (if applicable); (2) specific references to the pertinent plan provisions or IRS rules and regulations on which the decision is based; (3) a description of available external review procedures, including information regarding how to request an external review of the internal appeals decision and the time frame within which to submit such a request; and (4) the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman to assist you with the external review procedures.

If you do not receive an approval or denial of your appeal within the initial time period for review of your appeal, your appeal will be deemed to have received a final internal adverse benefit determination subject to external review.

Do I have the right to seek a review of a final internal adverse claim determination to an external third party? You have the right to an external review of the Plan's denial of your internal appeal, unless the denial was based on your (or your spouse's or dependent's) failure to meet the Plan's

eligibility requirements.

Is there a deadline for filing my request for external review? Yes. You must file your request for external review not later than the first day of the fifth month after you received notice from the Plan of, or are deemed to receive, a final internal adverse benefit determination. If you do not file your request for external review within this period, you lose your right to external appeal. For example, if you received or are deemed to receive your final internal adverse benefit determination on January 3 of any year, you must request external review by June 1 of the same year (or, if that is not a business day, the next business day thereafter).

What is the process for my external appeal? Within five business days after receiving the external review request, the Plan must complete a preliminary review to determine if: (1) you are covered under the Plan; (2) you provided all the information and forms necessary to process the external review; (3) you followed and exhausted the internal appeals procedures; and (4) the denial of your claim related to you (or your spouse or dependent) not meeting the eligibility requirements under the Plan, as claim denials based upon a failure to meet eligibility requirements are not subject to external review.

Within one business day after completion of its preliminary review, the Plan will provide you with written notice of the outcome of its review. If your request for external review is complete but the claim denial is not eligible for external review, the notice must state the reasons for ineligibility and include contact information for Employee Benefits Security Administration of the Department of Labor. If your request for external review is incomplete, the notice must describe the information and materials needed to complete the request, and you will be permitted to complete the request not later than the deadline for filing a request for external review, or 48 hours after your receipt of the Plan's preliminary review notice, whichever is later.

If the Plan receives a timely, completed, and eligible request for external review, the Plan will assign an independent review organization (IRO) to review the claim and you will receive written notice from the IRO that your request is eligible for external review and has been assigned to such IRO.

You will have the right to submit additional information in writing to the IRO within 10 business days after the date you receive notice from the IRO and, if the IRO receives any additional information within 10 business days after you receive such notice, then (1) the IRO must consider the additional information in its external review, and (2) the IRO is required to forward the additional information submitted by you to the Plan within one business day after the date the IRO receives the information.

Within five business days after the date the IRO receives the external review assignment, the Plan is required to provide the IRO with all documents and information considered by the Plan in making its decision to deny the claim and internal appeal.

Upon receiving from the IRO any additional information

submitted by you, the Plan may reconsider its previous decision. If the Plan reverses its decision upon such review, it will notify you and the IRO within one business day after making its reversal, and the IRO must terminate its external review. The IRO is not bound by the prior decision of the Plan in making its external review decision.

When will I be notified of the decision on my external appeal? The external reviewer must notify you and the Plan of its decision on your external appeal within 45 days after its receipt of your request for external review.

What information will be included in the IRO's decision on my external appeal? The notice to you of the IRO's external appeal decision will include the following information: (1) a general description of the reason for the external review request, including information sufficient to identify the claim, including the date(s) of service, the provider, the claim amount (if any), and the reason for the prior denial; (2) the date the IRO received the assignment to conduct the external review, and the date of the IRO's decision; (3) references to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards; (4) a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision; (5) a statement that the IRO's decision is binding, unless other remedies are available to you or the Plan under state or federal law; (6) a statement that judicial review may be available to you; and (7) a phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Is the external reviewer's decision binding? The external reviewer's decision is binding upon the parties but does not terminate or preempt your right or the Plan's right to pursue other state or federal law remedies. However, such remedies may or may not exist. Therefore, unless another legal right exists for your claim, the external reviewer's decision will be binding.

Part V Choosing Your Investment Allocation

The Plan's available fund lineup allows you to self-direct the investment of your HRA assets. You can invest in just one fund or any combination of two or more funds. The **HRA Dashboard** included with your welcome packet confirms your initial investment allocation, which you can update as needed (see Allocation Changes below).

Before investing, you should carefully consider each fund's target risk level, time horizon, objectives, risks, fees, charges, and expenses. This and other important information is contained in the prospectus for each fund, which you should read. For links to fund prospectuses, fact sheets, and historical performance, log in at **IAFFHealthTrustHRA.com** and click **Investments**.

Contributions and Withdrawals (claims). HRA contributions

or transfers are deposited according to your asset allocation percentages on file. Withdrawals (claims) are deducted pro rata based on your investment holdings at the time of claim.

Investment Risk. Fund values fluctuate on a daily basis. Withdrawals (claims) may be worth more or less than your original investment. Any investment that contains stocks or bonds entails the risk of loss. Investment returns, particularly over shorter time horizons, are highly dependent on investment market trends. Investing in stocks and bonds is suitable primarily as a longer-term strategy and should be considered carefully if you plan to file claims. Generally, investments with higher potential returns involve greater risk and more volatility. Past performance does not guarantee future results. Funds are not FDIC insured, are not guaranteed by a bank, and may lose value.

Periodic Review. It's a good idea for all investors to periodically revisit their investments and asset allocations. This helps make sure their investment choices remain aligned with their current investing goals and time horizons.

Allocation Changes. If you need to change your investment allocation, log in at IAFFHealthTrustHRA.com and click **Investments**. Changes are allowed once per calendar month.

Allocation changes become effective and visible online within two to three business days after receipt.

Investment Advice. You're encouraged to seek advice from your personal financial advisor before making investment decisions. The Plan service providers and Customer Care Center do not give investment advice.

Fund Operating Expenses. Fund operating expenses are deducted from fund assets and include management fees, distribution (12b-1) fees, and other expenses.

Part VI Premium Tax Credit (Subsidy) and Your HRA

You may qualify for the Premium Tax Credit (subsidy) if you or a family member purchase health insurance through a state or federal marketplace exchange (sometimes referred to as "Obamacare"). The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through an exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your out-of-pocket premium amount, or you can wait until you file your tax return.

Please note the following if you purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit: (1) Marketplace exchange premiums that are not subsidized by the Premium Tax Credit can be reimbursed from a full-coverage HRA; (2) Marketplace exchange premiums that are subsidized by the Premium Tax Credit cannot be reimbursed from your HRA; and (3) You may not qualify for the Premium Tax Credit for any month during which you have a full-coverage HRA. If you have a full-coverage HRA, are

claims-eligible, and have a positive HRA balance or are receiving ongoing HRA contributions, then it may make sense for you to either use up or limit your HRA, as described in more detail below. If you decide to take one of these actions, you should do so before taking the Premium Tax Credit in advance.

Keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you cannot qualify for the Premium Tax Credit and you do not need to use up or limit your HRA: (1) You are eligible for employer-sponsored group health plan coverage that meets the affordability and minimum value requirements under federal healthcare reform law. (If you are not sure whether this applies to you, check with your employer.); (2) You are eligible for coverage under a governmental plan such as Medicaid, Medicare, CHIP, or TRICARE; (3) Your total family income, including income from investments, retirement benefits, and Social Security, exceeds the maximum amount for eligibility for the Premium Tax Credit (400% of the federal poverty level); (4) You are married but do not file a joint tax return; or (5) You are claimed as a dependent on someone else's tax return.

What if my full-coverage HRA is the only thing keeping me from qualifying for the Premium Tax Credit? If you are claims-eligible and your full-coverage HRA is the only reason you cannot qualify for the Premium Tax Credit, you may consider one of these two options: **(1) Using up your HRA before taking the Premium Tax Credit.** You do not have to take the Premium Tax Credit right away. You could first use up your HRA to reimburse your non-subsidized premiums (and any other qualified medical care expenses incurred since your claims-eligibility date). Then, you could begin taking the Premium Tax Credit in advance to lower your monthly premium, or wait and claim it on your tax return, but only for premiums you paid after using up your HRA. Keep in mind that, if you receive any additional HRA contributions after using up your balance, you will lose eligibility for the Premium Tax Credit for any months during which you have (or had) a positive balance in your HRA. **(2) Electing Limited HRA coverage.** If you elect Limited HRA coverage, your HRA will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations). If you elect Limited HRA coverage for Premium Tax Credit eligibility, you can switch your HRA back to full coverage for any period that you are not taking the Premium Tax Credit. Limited HRA coverage is designed as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal healthcare reform law. To elect Limited HRA coverage, submit a **Limited HRA Coverage Election** form. Forms are available after logging in at IAFFHealthTrustHRA.com and clicking **Resources**, or contact our Customer Care Center (see front page).

Consider your options carefully. You should seek advice from a tax professional. The best decision may vary depending on your individual circumstances, including the amount in your HRA compared to the subsidy amount you could receive. Keep in mind that if you take the Premium Tax Credit without first using up or limiting your HRA as described above, you will likely not qualify for the Premium Tax Credit and may be required to pay it back when you file your tax return.

Where can I get more information? This SPD is intended to provide you with general information about the Premium Tax Credit and the options available to you under the Plan. For more information, go to www.irs.gov and type "Premium Tax Credit" in the search bar.

Part VII

Coordination of Benefits with Medicare and MMSEA Section 111 Reporting

If you're entitled to Medicare and your HRA is [fully] claims eligible, federal law governs whether your HRA or Medicare should be the first to reimburse or pay your medical expenses. The following summarizes the priority of claims payment as between your HRA account and Medicare unless you have elected Limited HRA coverage. For more information about electing Limited HRA coverage, refer to Part II of this SPD.

To comply with federal law, you should file your claims in accordance with these primary and secondary payer rules if you have a claims-eligible HRA and have not elected Limited HRA coverage: (1) If you or your spouse

are entitled to Medicare benefits due to your age, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (2) If you, your spouse, or dependents are entitled to Medicare benefits due to a disability, and you are currently employed and have a claims-eligible HRA account through your employer, your HRA account is primary to Medicare. You should file claims against your HRA account prior to submitting expenses or claims to Medicare. (3) If you, your spouse, or dependents are entitled to Medicare benefits due to end-stage renal disease (ESRD), and you have an active HRA account (regardless of your employment or retirement status), your account is primary to Medicare for the first 30 months of your Medicare eligibility.

During the first 30 months of your Medicare eligibility, you should file claims against your HRA account prior to submitting expenses or claims to Medicare.

MMSEA Section 111 Reporting. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires the Plan to report specific information about your HRA to the Centers for Medicare and Medicaid Services (CMS), unless you have elected Limited HRA coverage or certain other exceptions apply. For more information about electing Limited HRA coverage, refer to Part II of this SPD.

To comply with this federal law, the Plan requires you to provide information necessary to comply with the MMSEA Section 111 reporting requirements when you file a claim to your HRA. In addition, when submitting claims for reimbursement or coverage under your HRA and/or Medicare, you should follow the primary and secondary payer rules summarized above. If you have any questions about MMSEA Section 111 reporting or about who should reimburse or pay first, contact our Customer Care Center (see front page) or call

the Medicare Coordination of Benefits Contractor a 1-800-999-1118. TTY users should call 1-800-318-8782.

Part VIII

Regulatory Compliance; Required Notices

The Plan complies with the following requirements and does not discriminate with regard to a participant's health status, genetic information, age, disability, gender, race, or religious beliefs: Genetic Information Nondiscrimination Act (GINA); Age Discrimination in Employment Act (ADEA); Americans with Disabilities Act (ADA); Title VII of the Civil Rights Act and the Pregnancy Discrimination Act (PDA); HIPAA portability, privacy, and security requirements; Mental Health Parity Act (MHPA); and Mental Health Parity and Addiction Equity Act (MHPAEA).

Eligible expenses are defined in Internal Revenue Code § 213(d), but benefits may be limited by your HRA coverage or account balance.

COBRA NOTICE: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides eligible participants and those covered by this plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered dependents should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to our Customer Care Center (see front page).

General Information. A qualifying event is an event resulting in the loss of continued employer contributions and/ or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as qualified beneficiaries. Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or qualified beneficiary is required to notify the Plan within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage.

Qualifying Events. If you are a **participating employee**, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct); or (2) you

experience a reduction in hours affecting eligibility. If you are the **spouse** of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) you become divorced or legally separated from employee; or (4) employee passes away. **Qualified dependents** of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) employee and spouse become divorced or legally separated; (4) child reaches age limitation or no longer meets the definition of qualifying child; or (5) employee passes away.

Qualifying Event Notification. The Plan will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits. When the qualifying event is due to an active participating employee's voluntary or involuntary termination (other than for gross misconduct), reduction of hours of employment affecting eligibility, or death, the employer must notify the Plan within 30 days of the occurrence of such event. All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the Plan within 60 days of the occurrence of such event, using the **COBRA Event Notice** form. The Notice must be mailed or hand delivered to the Plan, and is available upon request from the Customer Care Center (see front page). A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation and additional documentation may be required. If the Notice is late, incomplete, or is not submitted as outlined in the Notice of Procedures provided on the aforementioned form, no qualified beneficiary may be offered the opportunity to elect COBRA coverage.

COBRA Continuation Period. The COBRA continuation period is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA. COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's voluntary or involuntary termination (other than for gross misconduct) or reduction of hours of employment affecting eligibility. A maximum of up to 36 months is allowed when the qualifying event is due to a participating employee's legal separation or divorce, death, or when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA Continuation Period Extension. If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the

qualified beneficiary(ies) must notify the Plan within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period. Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of a qualifying child), or death, the covered spouse and/or covered dependents may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the Plan within 60 days of the occurrence of the second qualifying event.

Information Resources. Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to our Customer Care Center (see front page), or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA RIGHTS: If you are on military leave governed by the Uniformed Services Employment and Re-employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents. If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to, apply for or return to a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

FMLA NOTICE: The Plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your HRA, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave. For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

WOMENS' HEALTH AND CANCER RIGHTS ACT NOTICE: The Plan will provide coverage for all stages of reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to provide a symmetrical appearance; prostheses; and coverage of physical complications at all stages of the mastectomy, including lymphedemas. Availability of benefits may be limited by your HRA coverage and account balance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier

than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Availability of benefits may be limited by your HRA coverage and account balance.

TRICARE: Under statutory amendments enacted in 2006, and final regulations issued in 2010, employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under the military's healthcare program, known as TRICARE. In particular, employers are prohibited from providing financial or other incentives for TRICARE-eligible employees not to enroll (or to terminate enrollment) under a group health plan that would (in the case of such enrollment) be a primary plan. Due to these federal regulations, if you are a TRICARE-eligible employee, your employer may be required to direct your contributions to an HRA with post-separation benefits (claims-eligibility) only.

HRA Plan coverage is not primary to your employer's group health plan.

MEDICAL SUPPORT ORDERS: Participants and covered individuals may obtain a copy of the qualified medical support order procedure from the Plan, free of charge. To request a copy, please contact our Customer Care Center (see front page).

PRIVACY NOTICE: This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

This Privacy Notice (the "Notice") describes the legal obligations of IAFF Health & Wellness Trust HRA (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, PHI is health information, including demographic information, collected from you or created or received by the Plan from which it is possible to individually identify you and relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Questions about this Notice or our privacy practices should be directed to the Plan's Customer Care Center, at **1-833-719-7197**.

Effective date

This Notice is effective July 1, 2026.

Privacy pledge – our responsibility

We are required by law to: (1) make sure PHI identifying you is kept private; (2) give you certain rights with respect to your PHI; (3) provide this Notice of our legal duties and privacy/security practices concerning PHI about you; and (4) follow the terms of the Notice currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make a material change to the Notice, we will provide you with a copy of our revised Privacy Notice by posting it on the Plan website and include information about the revised Notice and how to get a copy in your next eligible participant account statement delivery.

How we may use and disclose PHI about you

The following categories describe various ways we use and disclose PHI. Explanations and examples are provided for each category of uses or disclosures. Not every use or disclosure is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **For payment** (as described in applicable regulations). We may use and disclose PHI about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is medically necessary, or to determine whether the Plan will cover the treatment. We may also share PHI with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.
- **For health care operations** (as described in applicable regulations). We may use and disclose PHI about you for other Plan operations necessary to run the Plan. For example, we may use PHI in connection with conducting quality assessment and improvement activities; other activities relating to Plan coverage; conducting or arranging for legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.
- **To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI.
- **As required by law.** We will disclose PHI about you when required to do so by federal, state, or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding such as a malpractice action.

- **To avert a serious threat to health or safety.** We may use and disclose PHI about you, when necessary, to prevent a serious threat to your health and safety, or the health and safety of the public or another person, but only to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a physician.
- **To Employers or Plan Sponsors.** For the purpose of administering the plan, we may disclose PHI to certain employees of your Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise permitted by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization.

- **Military and veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' compensation.** We may release PHI about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.
- **Public health risks.** We may disclose PHI about you for public health activities such as to: (1) prevent or control disease, injury, or disability; (2) report births and deaths; (3) report child abuse or neglect; (4) report reactions to medications or problems with products; (5) notify people of recalls of products they might be using; (6) notify a person who might have been exposed to a disease or might be at risk for contracting or spreading a disease or condition; or (7) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).
- **Health oversight activities.** We may disclose PHI to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections, and licensure necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request, or to obtain an order protecting the information requested.
- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to

obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at the hospital; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

- **National security and intelligence activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

- **Government audits.** We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
- **Disclosures to you.** When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

Other Disclosures

- **Personal representatives.** We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Spouses and other family members.** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your

rights regarding PHI about you”), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

- **Authorizations.** Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your rights regarding PHI about you

You have the following rights regarding PHI we maintain about you.

- **Right to inspect and copy.** You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy. To inspect and copy such information, you must submit a written request to the Plan. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, in which case you may request that the denial be reviewed.
- **Right to amend.** If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, you must submit a written request to the Plan including a reason that supports your request. Your request may be denied if it is not in writing or does not include a reason to support the request, or if you ask us to amend information that: (1) is not part of the PHI kept by or for the Plan; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
- **Right to an accounting of disclosures.** You have the right to request an “accounting” of certain disclosures of your PHI. The accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Plan. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to request restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, health care operations, or to someone who is involved in your care, or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as provided later in this paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full. To request restrictions, you must submit a written request to the Plan detailing: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (i.e., your spouse).
- **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the Plan specifying how or where you wish to be contacted. We will not ask the reason and will accommodate all reasonable requests.
- **Right to be notified of breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured PHI.
- **Right to a paper copy of this Notice.** You have the right to a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. You may obtain a paper copy of this Notice on our website at IAFFHealthTrustHRA.com or by contacting our Customer Care Center at 1-833-719-7197.

Substance Use Disorder Records

The Plan will not use or disclose your substance use disorder (“SUD”) records in civil, criminal, administrative, or legislative proceedings against you unless the Plan receives (i) written consent or (ii) a court order, after you have been provided notice and an opportunity to be heard. A court order authorizing use and disclosure of your SUD records must be accompanied by a subpoena or other legal requirement

compelling disclosure before the Plan can use or disclose such SUD records.

Other uses of PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written permission. Such permission may be revoked, in writing, at any time and we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the service we provided you.

Potential for Redisclosure

When your PHI is disclosed as described in this Notice, there is a potential it will be redisclosed by the person receiving the PHI and the PHI will no longer be subject to the protections described in this Notice and other applicable laws.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the IAFF Health & Wellness Trust Customer Care Center at 1-833-719-7197, and ask for your Plan Privacy Official's contact information. All complaints must be submitted in writing. You will not be penalized or otherwise retaliated against for filing a complaint.

Part IX

Exemption from Annual Limit Restrictions

The Affordable Care Act prohibits health plans from applying dollar limits on coverage for certain benefits. Your HRA has been designed based upon exemptions from these annual limit restrictions and in accordance with guidance issued by the Internal Revenue Service and the U.S. Department of Health and Human Services. Accordingly, your HRA reimbursements (claims) are limited to your available account balance. This means coverage provided to you by this Plan may not reimburse all of the out-of-pocket medical care expenses you may incur.

Part X

Terms & Conditions

By enrolling and participating in the Plan and taking any action with respect to your HRA benefits under the Plan, you agree to the following Terms & Conditions. You agree that the Plan and the parties involved in this Plan (including, but not limited to, the employer, plan sponsor, plan administrator, bargaining representative, the Master Trustee, the HRA Service Manager, Plan service providers, and the agents of each, collectively referred to as the "Plan and its agents") cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any

tax, charge, penalty, assessment, or other amount that is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan and its agents harmless with respect to such withholding or any failure to withhold or pay such amounts and any other actions taken in good faith for the operation of the Plan.

You understand that for proper administration of the Plan and compliance with applicable law, you must provide true and accurate information to the Plan and regularly confirm and update your enrollment information, including name, address, phone number, dependents, and social security numbers for yourself and your dependents. Information submitted to the Plan fraudulently may result in adverse tax consequences or penalties and/or your termination from the Plan. You also understand that it is your responsibility to review each statement to confirm that there are no investment or financial errors reflected on your account. Any errors must be reported by you to the Plan within ninety (90) days after the error is first viewed by you online or first reflected in a statement or other written information delivered to you by the Plan and its agents.

E-communication Terms & Conditions. For your e-communication election to be effective, you must provide the Plan with your e-mail address. The electronic documents you will receive include e-statement notifications and newsletters, claims processing notifications, and other important Plan information. Please note the following: (1) you may withdraw your consent for electronic documents at any time at no charge; (2) to update your e-communication election or email address, please login at IAFFHealthTrustHRA.com and click **My Profile** on the menu bar; (3) it is your responsibility to keep your email address current with the Plan. If your electronic documents are returned to the Plan due to an undeliverable e-mail address, the Plan may remove your e-communication election; (4) any electronically delivered documents will **not** be mailed to you by US Mail; and (5) you can view and print copies of your electronic documents or request paper copies (at no charge) from our Customer Care Center (see front page).

You will need Adobe Acrobat Reader software loaded on a computer in order to access electronic documents. A free copy of Adobe Acrobat Reader is available at www.adobe.com.

Appendix A

ERISA Supplement

This supplement contains additional information regarding your Plan and your rights under the Plan as required by ERISA. You may also receive a Summary of Material Modifications (SMM) from time to time, which is required by ERISA to provide you with timely notice of certain material changes to the Plan or information required to be included in the SPD. You should read the SPD (as updated from time to time), any SMMs, your welcome packet, and this supplement together to fully understand your benefits and your rights under the Plan. You may obtain a copy of the most current SPD and any SMMs by logging in at and clicking **Resources**. If you misplace your welcome packet, you may request a replacement copy from our Customer Care Center (see front page).

Your Rights. As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all Plan participants shall be entitled to the rights described below.

Receive Information about Your Plan and Benefits. You can examine, without charge, at the Plan's office and at other specified locations all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration. You can obtain, upon written request to the Plan, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan may make a reasonable charge for the copies. The Plan is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

Continue Group Health Plan Coverage. You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and covered individuals. No one, including your plan sponsor, employer, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within

certain time schedules. Be sure to review the Procedure for Disputed Claims under Part IV in this SPD for more details regarding your enforcement rights under the Plan.

After exhausting the Plan's claims procedures, under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, contact our Customer Care Center (see front page). If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Ask Questions

1-833-719-7197

More Information

IAFFHealthTrustHRA.com



IAFF Health & Wellness Trust

Investment advisory, named and independent fiduciary services are offered through Gallagher Fiduciary Advisors, LLC, an SEC Registered Investment Adviser. Gallagher Fiduciary Advisors, LLC may pay referral fees or other remuneration to employees of AJG or its affiliates or to independent contractors; such payments do not change our fee. This document contains confidential and proprietary information that belongs to Gallagher Fiduciary Advisors, LLC and is protected by copyright, trade secret and other State and Federal laws. Any copying, redistribution or retransmission of any of the contents without the written consent of Gallagher Fiduciary Advisors, LLC is expressly prohibited. Gallagher Fiduciary Advisors, LLC is a single-member limited-liability company with Gallagher Benefit Services, Inc. as its single member. Neither Arthur J. Gallagher & Co., Gallagher Fiduciary Advisors, LLC nor their affiliates provide accounting, legal or tax advice.



Governing Board Agenda Item

SUBJECT/TITLE: Resolution No. 2026-05 - Approving MSA/BAA with Gallagher for FSA Benefit Plan

STAFF CONTACT: Samantha Babich, Chief Administration Officer

SUMMARY STATEMENT:

Adopt a resolution approving the Master Services Agreement (MSA) and HIPAA Business Associate Agreement (BAA) with Gallagher Benefit Services, Inc. for continued third-party administration of RRFA's FSA Benefit Plan, and authorizing the Fire Chief to execute related agreements.

FISCAL IMPACT:

Expenditure N/A Revenue N/A
Currently in the Budget Yes ☐ No ☐ N/A ☒

SUMMARY OF ACTION:

RRFA's FSA Benefit Plan is administered by BPAS. This resolution approves moving the administration of the plan to Gallagher Benefit Services, Inc. (HealthInvest), following the same BPAS-to-Gallagher transition addressed in Resolution No. 2026-04. Specifically, this resolution approves the Master Services Agreement (MSA) and HIPAA Business Associate Agreement (BAA) required for Gallagher to continue that administration, effective October 1, 2026, and authorizes the Fire Chief to execute these and future related amendments, restatements, and renewals without further Board action, unless funding obligations or benefit structure materially change. The underlying FSA Plan Document, adopted by Resolution No. 2023-02, is not amended by this action.

Reviewed by Legal Yes ☒ No ☐ N/A ☐

EXHIBITS:

1. Resolution No. 2026-05
2. Master Services Agreement (MSA) with Gallagher Benefit Services, Inc. (with Pricing Appendix)
3. HIPAA Business Associate Agreement (BAA)
4. Resolution 2023-02 and RRFA FSA Plan Document as amended and restated

RFA GOVERNANCE BOARD RECOMMENDED ACTION:

Move to adopt Resolution No. 2026-05, approving the Master Services Agreement and HIPAA Business Associate Agreement with Gallagher Benefit Services, Inc. for the FSA Benefit Plan, and authorizing the Fire Chief to execute related agreements.

**RENTON REGIONAL FIRE AUTHORITY
RESOLUTION NO. 2026-05**

**APPROVING THE MASTER SERVICES AGREEMENT AND HIPAA BUSINESS ASSOCIATE AGREEMENT WITH
GALLAGHER BENEFIT SERVICES, INC. FOR CONTINUED ADMINISTRATION OF THE FSA BENEFIT PLAN,
AND AUTHORIZING THE FIRE CHIEF TO EXECUTE RELATED AGREEMENTS**

WHEREAS, Renton Regional Fire Authority ("RRFA" or the "Employer") maintains a Flexible Spending Account (FSA) Benefit Plan, originally effective July 1, 2016, and most recently amended and restated by Resolution No. 2023-02; and

WHEREAS, RRFA has determined to transition administration of its HealthInvest benefit plans, including the FSA Benefit Plan, from BPAS to Gallagher Benefit Services, Inc., acting as HealthInvest Service Manager; and

WHEREAS, this transition in third-party administration does not amend, restate, or otherwise alter the terms of the FSA Plan Document adopted by Resolution No. 2023-02, which remains in full force and effect; and

WHEREAS, Gallagher Benefit Services, Inc. requires, as a condition of its engagement, that the Employer execute a Master Services Agreement setting forth the terms of the engagement and a HIPAA Business Associate Agreement governing the use and disclosure of protected health information in connection with the FSA Benefit Plan and RRFA's other HealthInvest benefit plans; and

WHEREAS, the Governing Board has reviewed the Master Services Agreement and the HIPAA Business Associate Agreement presented to this meeting, copies of which are attached hereto;

NOW, THEREFORE, BE IT HEREBY RESOLVED,

That the Master Services Agreement between RRFA and Gallagher Benefit Services, Inc., effective October 1, 2026, presented (a copy of which is attached hereto), is hereby approved; and

RESOLVED, that the HIPAA Business Associate Agreement between RRFA and Gallagher Benefit Services, Inc., effective October 1, 2026, presented (a copy of which is attached hereto), is hereby approved; and

RESOLVED, that the FSA Benefit Plan adopted by Resolution No. 2023-02 (a copy of which is attached hereto) shall continue in effect without amendment or restatement, and this Resolution approves only the administrative agreements governing the Plan's continued third-party administration; and

RESOLVED, that the Fire Chief or designee is hereby authorized, on behalf of RRFA, to execute and deliver the Master Services Agreement, the HIPAA Business Associate Agreement, and any related administrative agreements necessary to implement this transition, and to execute future amendments, restatements, renewals, and related administrative agreements as may from time to time be necessary to maintain these agreements on behalf of the Employer, without further action of the Governing Board unless such action would materially change the Employer's funding obligations or benefit structure.

ADOPTED by the Governing Board of Renton Regional Fire Authority, at an open public meeting of such Board on the 14th day of September, 2026, the following Board Members being present and voting:

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

HealthInvest Benefit Plans MASTER SERVICES AGREEMENT

This Master Services Agreement (this “Agreement” or “MSA”) is entered into and effective as of October 1, 2026, (the “Effective Date”) by and between Gallagher Benefit Services, Inc. (“Gallagher”), a Delaware corporation, in its capacity as the Service Manager under the HealthInvest Plan Documents (the “Service Manager”), and the entity that is named and has executed this Agreement on the signature page hereto (the “Plan Sponsor”).

WHEREAS, the Plan Sponsor, by formal action of its Governing Body or other authorized action, has formally approved the establishment of one or more employee welfare benefit plans (each a “Plan” or “Benefit Plan”); and

WHEREAS, the Plan Sponsor desires to engage Gallagher to perform some or all of the Services described herein and to use Gallagher’s proprietary plan documents (referred to herein as the “HealthInvest Plan Documents” or “Plan Documents”) to implement and administer the Plan Sponsor’s Benefit Plans; and

WHEREAS, Gallagher and the Plan Sponsor desire to set forth the terms and conditions of the Plan Sponsor’s engagement of Gallagher to perform the Services elected by the Plan Sponsor with respect to the administration of the Plan Sponsor’s Benefit Plans and use of the HealthInvest Plan Documents.

NOW, THEREFORE, the parties hereto agree as follows:

1. Engagement of Gallagher by Plan Sponsor; Services. The Plan Sponsor shall serve as the plan administrator responsible for overseeing and supervising the administration of the Plan Sponsor’s Benefit Plans (the “Plan Administrator” or the “Administrator”) or may in its Onboarding and Renewal Summary (defined in Section 3 below) designate one or more representatives who may act on behalf of the Plan Sponsor in its capacity as the Plan Administrator. Without relieving the Administrator of any of its obligations under the Benefit Plans, the Plan Sponsor hereby engages Gallagher to provide ministerial and non-discretionary services, including (i) “Administration Support Services” provided by the HealthInvest Service Manager as defined and otherwise specified in the Plan Documents, (ii) the services described in each Administrative Services Appendix (defined below) and attached hereto (as elected by the Plan Sponsor from time to time in an Onboarding and Renewal Summary, and (iii) other services at the direction of the Plan Sponsor or Administrator that Gallagher agrees to perform (collectively, the “Services”). The Plan Sponsor authorizes and appoints Gallagher as the HealthInvest Service Manager under the Plan Documents or as otherwise specified or permitted under the Plan Documents to assist the Administrator in the performance and execution of all of the duties, powers, and responsibilities of the Administrator specifically defined in the Plan Documents, subject to the approval and direction of the Administrator or Plan Sponsor for any such duties, powers, or responsibilities that require the discretion of the Administrator or that are not otherwise specifically prescribed in the Plan Documents. Gallagher acknowledges and agrees that the performance of the Services hereunder by Gallagher and its agents and subcontractors shall be performed in a manner reasonably intended to comply with applicable law and the terms of the Plan Sponsor’s Benefit Plans and with a standard of care, skill, and diligence consistent with practices and procedures used in well-managed operations performing services comparable to the Services to be performed by Gallagher hereunder. In addition, Gallagher will, and will cause each of its subcontractors to,

obtain and maintain at its own cost all licenses and registrations required by state and federal law to operate its business and to perform its services hereunder.

2. Fiduciary Status and Discretionary Authority.

(a) The Plan Sponsor acknowledges and agrees that the appointment of Gallagher to perform its Services is not intended to transfer fiduciary status or liability to Gallagher. The Plan Sponsor retains final, discretionary authority and responsibility to construe the terms of the Benefit Plans, monitor the performance of service providers, and control the Plan's assets. To the extent the Plan Sponsor delegates duties or responsibilities to Gallagher (whether directly or through the terms hereof or of the Plan Documents), Gallagher shall not be deemed to be making discretionary decisions in fulfilling those duties or responsibilities, so long as Gallagher is fulfilling those responsibilities in accordance with the Plan Documents or in accordance with the direction of the Plan Sponsor. It is the intention of the Plan Sponsor and Gallagher that Gallagher's claims administration services shall not be considered discretionary to the extent that Gallagher (or any of its subcontractors) is evaluating the validity or authenticity of documentation presented for substantiation and evaluation as to whether the expense for which reimbursement is requested is a qualified expense under applicable law. Notwithstanding the foregoing, Gallagher acknowledges and accepts any fiduciary status or responsibility that may arise under applicable law as a result of any action or inaction that is deemed to be an exercise of discretion or conflict of interest on its part in connection with the Services provided hereunder.

(b) The Plan Sponsor shall have the sole responsibility and final authority to determine whether any individual is eligible to enroll in or entitled to coverage under the Benefit Plans, and how coverage and payments for coverage of various benefit options under the Benefit Plans will be administered under leaves of absence. The Plan Sponsor shall furnish to Gallagher, in a manner and frequency to be determined by the parties, eligibility and contribution information regarding Plan participants (including employment terminations and other status changes that affect coverage under the Benefit Plans or benefit options administered by Gallagher) and shall update such eligibility and contribution information as soon as possible after any change has occurred. Gallagher shall not be responsible for the accuracy or completeness of the eligibility and funding information provided to it by the Plan Sponsor or the Plan Administrator and shall have no obligation or duty to determine or verify whether such information is accurate or complete or made in accordance with the obligations, policies, or legal requirements of Plan Sponsor with respect to the same.

3. Administrative Services Appendices; Pricing Appendix; Onboarding and Renewal Summary.

(a) The Services provided by Gallagher will include the Services described in each administrative services appendix attached hereto (each an "Administrative Services Appendix" or "ASA"), with respect only to such services that have been elected by the Plan Sponsor pursuant to an Onboarding and Renewal Summary (defined below). The Plan Sponsor and Gallagher hereby agree to the description of Services, and other terms and conditions set forth in each ASA that is applicable to the Services elected by the Plan Sponsor and to the Compensation and Expenses with respect to each of the elected Services, as set forth in the "Pricing Appendix" attached hereto, which includes and incorporates by reference the Pricing Sheet delivered to and approved by the Plan Sponsor in connection with its execution of this Agreement (as the same may be amended or restated from time to time in accordance with Sections 6 and 21 hereof).

(b) An “Onboarding and Renewal Summary” is a summary of benefit and plan design elections and other Plan Sponsor or Plan information completed by the Plan Sponsor with the assistance of Gallagher during initial onboarding of the Services and updated or amended and restated from time to time in connection with annual renewals of the Benefit Plans, annual service reviews, or as otherwise mutually agreed.

(c) Upon mutual completion of the Onboarding and Renewal Summary, Gallagher will deliver the completed Onboarding and Renewal Summary to the Plan Sponsor through the secure message feature of the Plan Sponsor’s employer portal or by email. The Onboarding and Renewal Summary will be deemed approved by the Plan Sponsor upon approval by the Plan Sponsor delivered electronically through the secure message feature, by email, or if the Plan Sponsor has not rejected the completed Onboarding and Renewal Summary within ten (10) business days of delivery by Gallagher. References in this MSA to an Onboarding and Renewal Summary shall be deemed to refer to the most current Onboarding and Renewal Summary approved or deemed approved by the Plan Sponsor pursuant to the process prescribed in this Section.

(d) Gallagher may update the Onboarding and Renewal Summary from time to time to ensure that Gallagher has complete, accurate, and up-to-date information to effectively and efficiently perform the Services. An updated Onboarding and Renewal Summary template shall be used for any future amendment and restatement of the Plan Sponsor’s most current Onboarding and Renewal Summary and shall have no impact on the Plan Sponsor’s benefits or plan design elections or other information until the new template is completed and approved by the Plan Sponsor pursuant to the process prescribed in this Section 3.

(e) The most recently approved Onboarding and Renewal Summary, Pricing Appendix, and any ASA elected by the Plan Sponsor pursuant to the Onboarding and Renewal Summary, are hereby incorporated into and made a part of this Agreement for all purposes and shall be governed by, construed and subject to the terms and conditions of this Agreement, except as provided otherwise by the specific terms of the ASA. References herein to “this Agreement” or “this MSA” shall mean this Agreement or this MSA, including the Onboarding and Renewal Summary, Pricing Appendix, and any ASA incorporated into and made a part hereof. References to “Agreement” or “MSA” in the Onboarding and Renewal Summary, any ASA or the Pricing Appendix shall mean this Agreement or this MSA together with the Onboarding Summary, the Pricing Appendix, and any ASA elected by the Plan Sponsor pursuant to the Onboarding and Renewal Summary.

4. Investment Manager. In the event Plan Sponsor desires to use a Gallagher affiliate to provide certain investment consulting services, Plan Sponsor will enter into a separate Investment Management Agreement in the same or similar form as Addendum C.

5. Compensation and Expenses; Regulatory Fees and Governmental Assessments.

(a) Compensation and Expenses. The Plan Sponsor accepts and agrees to the schedule of (i) direct compensation in the form of fees and expenses and (ii) indirect compensation Gallagher may receive in connection with the Services, in each case as set forth in the Pricing Appendix (“Compensation and Expenses”). The Plan Sponsor acknowledges and agrees that, to the extent permitted by law, direct compensation in the form of fees and expenses will be paid by the Plan Sponsor or out of Plan assets (*i.e.*, assessed against benefits accounts or employer

accounts) in the manner described in the Pricing Appendix or as otherwise determined by the Plan Sponsor.

(b) Regulatory Fees and Expenses. The Plan Sponsor accepts and agrees to the schedule of regulatory fees and expenses that are set forth in the Pricing Appendix and acknowledges and agrees that, to the extent permitted by law, such regulatory fees and expenses will be paid by the Plan Sponsor or out of Plan assets (*i.e.*, assessed against benefits accounts or employer accounts) in the manner described in the Pricing Appendix or as otherwise determined by the Plan Sponsor. Gallagher shall provide the Plan Sponsor advance written notice in accordance with Section 19 hereof (“Official Notice”) of any increase in regulatory fees and expenses due to a change in applicable law and will notify the Plan Sponsor in writing of any new governmentally imposed fee, tax, or assessment (“Governmental Assessment”) that may be prescribed and applicable to the Plan Sponsor, Participating Employers (as defined in Section 9(c)), or the Plans from time to time, and the Plan Sponsor acknowledges and agrees that the Plan Sponsor shall be liable for payment of such Governmental Assessment unless the applicable law or regulation imposing such Governmental Assessment permits such fee to be assessed against Plan assets or requires that it be paid directly by Gallagher, in which case the Plan Sponsor agrees to reimburse Gallagher for any Governmental Assessment applicable to the Plan Sponsor, a Participating Employer, or the Benefit Plans that is required by applicable law or regulation to be paid directly by Gallagher. If the Plan Sponsor notifies Gallagher in writing that any such Governmental Assessment is not lawfully or properly assessed, or is questionable, the Plan Sponsor may contest the validity thereof in any manner deemed appropriate by the Plan Sponsor. The Plan Sponsor hereby agrees to indemnify and hold Gallagher harmless in accordance with Section 13 hereof from any liability arising from the Plan Sponsor’s contest of or failure or refusal to pay any Governmental Assessment.

(c) Change in Compensation and Expenses or Regulatory Fees and Expenses. Except as provided below, Compensation and Expenses set forth in the Pricing Appendix may be amended from time to time in accordance with Sections 6 and 21 hereof. Notwithstanding the foregoing, unless otherwise agreed in any Onboarding and Renewal Summary or otherwise in writing between Gallagher and the Plan Sponsor, on an annual basis Gallagher shall have the right, without prior notice or approval of the Plan Sponsor, to increase its administration fees by an amount not to exceed 5% to accommodate increases in its cost to provide Services.

6. Additional Services. The Plan Sponsor and Gallagher may mutually agree on additional Services to be provided for an additional fee. Any additional Services shall be agreed upon pursuant to an amendment and restatement of the applicable ASA and any applicable amendment or restatement of the Pricing Appendix approved by the Plan Sponsor as provided in Sections 3, 5, 6, or 21 hereof, as applicable. Notwithstanding the foregoing, Plan Sponsor agrees that Gallagher may from time to time and for no additional compensation to Gallagher or expense to the Plan Sponsor, independently expand or improve the Services for the benefit of the Plan Sponsor, Participating Employers, or Participants without prior approval of the Plan Sponsor. With respect to such expansion or improvement of Services, Gallagher shall deliver a unilaterally amended and restated ASA to the Plan Sponsor, and unless the Plan Sponsor objects to the amended and restated ASA within thirty (30) days of receipt from Gallagher, the Plan Sponsor shall be deemed to have accepted and agreed to it. Expansion or improvement of the Services in this manner for the benefit of the Plan Sponsor, Participating Employers, or Participants is subject to Plan Sponsor’s right to remove Gallagher and Gallagher’s right to resign as provided herein.

To the extent that Gallagher offers additional Services in the future, Gallagher may unilaterally amend or restate this MSA pursuant to Section 21 hereof to add a new ASA or amend or restate

an existing Appendix to add the additional Services and applicable fees or other compensation as set forth in the most current approved Pricing Appendix, which the Plan Sponsor may elect pursuant to an Onboarding and Renewal Summary.

7. Subcontractors; Compensation to Service Providers. The Plan Sponsor authorizes Gallagher to engage at its own expense one or more agents or sub-contractors to carry out the Services to be performed by Gallagher; provided that, Gallagher shall remain responsible for the delivery of all Services covered by this Agreement and each ASA and shall be liable for the acts or omissions of its agents or sub-contractors to the same extent as if Gallagher were performing such Services. In addition, the Plan Sponsor hereby authorizes Gallagher to arrange for or cause the reasonable and necessary compensation and expenses of other Plan service providers (including those engaged directly by or at the direction of the Plan Sponsor or the Administrator) to be: (i) invoiced to and collected from the Plan Sponsor; (ii) paid out of Plan assets by assessment of benefits accounts or employer accounts as plan administration expenses to the fullest extent permitted by applicable law and as specified in the Pricing Appendix; or (iii) paid as otherwise approved in writing by the Plan Sponsor.

8. Use of HealthInvest Plan Documents; Amendments.

(a) The HealthInvest Plan Documents, including any Summary Plan Description for any HealthInvest Benefit Plan covered by this Agreement, will cover the terms and conditions, provisions, and disclosures required by applicable law only for the HealthInvest Benefit Plans and not for any other benefit plan of the Plan Sponsor that is not covered by this Agreement.

(b) The Plan Sponsor agrees that it may utilize the HealthInvest Plan Documents only while Gallagher is engaged hereunder and appointed as the HealthInvest Service Manager under the HealthInvest Plan Documents. Upon resignation by or removal of Gallagher as provided herein, the Plan Sponsor shall no longer have the right to utilize Gallagher's proprietary HealthInvest Plan Documents, and any use of the HealthInvest Plan Documents by the Plan Sponsor after the resignation by or removal of Gallagher as the HealthInvest Service Manager for the Plan Sponsor's Benefit Plan is subject to the Plan Sponsor's indemnification obligations hereunder.

(c) The Plan Sponsor understands and agrees that the HealthInvest Plan Documents will be used by multiple plan sponsors and employers who have adopted the HealthInvest Plan Documents and for which Gallagher provides Administrative Support Services. As part of its Services, Gallagher may cause one or more of the Plan Documents, plan literature, educational materials, or plan forms to be amended, restated, or replaced from time to time. Any amendments or other changes to any of the HealthInvest Plan Documents will be communicated to the Plan Sponsor at least sixty (60) days in advance of the proposed amendment or change (unless applicable law required implementation of the change into the plan documents sooner). In order to provide the Services effectively for the Plan Sponsor and other plan sponsors and employers who utilize Gallagher's services and proprietary HealthInvest Plan Documents (and unless otherwise specifically provided in a particular HealthInvest Plan Document), the Plan Sponsor agrees that, unless the Plan Sponsor objects in writing to the amendment or change to any HealthInvest Plan Document within thirty (30) days of receipt from Gallagher, the Plan Sponsor shall be deemed to have accepted and agreed to it. Approval of the HealthInvest Plan Document amendments or changes in this manner are subject to Plan Sponsor's right to remove Gallagher and Gallagher's right to resign as provided herein.

(d) The Plan Sponsor further understands and agrees that unilateral amendments requested by the Plan Sponsor may not be accepted by Gallagher if Gallagher determines that it would be unable to amend the HealthInvest Plan Document for all plans who utilize its services or would be unable to effectively provide the Services to the Plan Sponsor's Plans or plans of other plan sponsors in the light of such proposed amendment. Accordingly, any Plan or Plan Document amendment proposed by the Plan Sponsor must be submitted to Gallagher, and such amendment shall not take effect until Gallagher delivers written acceptance of the amendment. The Plan Sponsor's right to unilaterally amend the terms and conditions of any Plan Sponsor Benefit Plan and any applicable Plan Document, and Gallagher's right to accept or not accept an amendment, are subject to Gallagher's right to resign and the Plan Sponsor's right to remove Gallagher pursuant hereto.

9. Plan Adoption; Participating Employers (as applicable).

(a) Plan Sponsor/Employer Information. To assist Gallagher in the performance of its Services, the Plan Sponsor agrees to provide Gallagher information upon request regarding internal resources of the Plan Sponsor who are responsible for working with Gallagher in connection with the administration of the Plan Sponsor's HealthInvest Benefit Plans. In its Onboarding and Renewal Summary, the Plan Sponsor will also provide the address for notices delivered pursuant to Section 19 hereof and the name and contact information for internal personnel (which may be only one individual) who will serve as the Privacy and Security Official(s) on behalf of the Plan Sponsor's Plans and to provide Gallagher with timely updates to Privacy Official and Security Official contact information as it may change from time to time. The Plan Sponsor's Privacy and Security Official(s) will be the primary contact(s) for all HIPAA privacy and security matters affecting the Benefit Plans.

(b) The Plan Sponsor agrees to execute one or more Plan Adoption Agreements pursuant to which, among other things, the Plan Sponsor will adopt the applicable HealthInvest Benefit Plans and the HealthInvest Plan Documents for its Benefit Plans.

(c) If the Plan Sponsor's Plan will be made available by the Plan Sponsor to one or more employers participating in a multi-employer or multiple employer plan, or would include subsidiaries or other affiliates of the Plan Sponsor within a "control group" as determined by Department of Labor regulations using common control rules set forth in Sections 414(c) and 1563 of the Code (in each case a "Participating Employer"), the Plan Sponsor agrees as follows:

- (i) The Plan Sponsor shall cause each Participating Employer to provide the information required under Section 9(a), and if requested by Gallagher, to execute one or more Plan Adoption Agreements, as required to adopt one or more Benefit Plans;
- (ii) Plan Sponsor accepts full responsibility for compliance by any Participating Employer with the terms and conditions of this Agreement and the Plan Documents; and
- (iii) When the term "Employer" is used in any of the HealthInvest Plan Documents, "Employer" means the Plan Sponsor to the extent the Plan Sponsor is acting as an Employer and shall mean a Participating Employer other than the Plan Sponsor to the extent the Participating Employer is acting as the Employer in accordance with the terms of the Plan Documents.

(d) If the Plan Sponsor's Plan will not be made available to one or more Participating Employers, then Gallagher and the Plan Sponsor agree that all references to the term "Employer" in this MSA and the HealthInvest Plan Documents shall mean the Plan Sponsor acting in its capacity as the Employer under the Plan, and all references to Participating Employers shall not apply and shall be ignored for all purposes.

(e) In its Onboarding and Renewal Summary, the Plan Sponsor or a Participating Employer may amend certain terms and conditions of its Plan, including contribution funding methods and levels, eligibility requirements, and other variable Plan features, at any time, provided, however, that no such amendment may be prohibited by applicable law or any trust established in connection with the Plan, and any such amendment shall be subject to acceptance by Gallagher (including confirmation that Gallagher can continue to provide Administration Support Services or the Services on behalf of the Plan Sponsor or Participating Employer) and the Plan Sponsor's acceptance of any additional fees or charges that may result from such changes to the Plan.

10. Records. Gallagher shall maintain books, records, participant-level paperwork and documentation, and data concerning the Services (the "Records") and retain such Records for a minimum of seven (7) years after the end of the calendar year in which they are collected, or for any longer period or shorter period if such longer or shorter period is required by applicable law. Gallagher may retain Records in either electronic or hard copy format. Upon the termination or expiration of this Agreement, or if requested by the Plan Sponsor, Gallagher shall return or destroy all Records, to the extent permitted by applicable law, within sixty (60) days of such request; provided however that Gallagher may retain one copy of any Records for the purpose of complying with internal document preservation obligations, policies, or procedures or applicable law.

11. Term; Suspension of Services; Termination; Wind Down.

(a) Term. This Agreement is effective as of the Effective Date set forth above and shall remain in full force and effect until terminated by either party as provided herein. Each ASA and the Compensation and Expenses applicable to the ASA as set forth in the Pricing Appendix shall be effective as set forth in the Onboarding and Renewal Summary pursuant to which the Plan Sponsor elects the Services covered by the ASA.

(b) Suspension of Services. With respect to Services for any flexible spending account (FSA) Plan or any individual coverage HRA (ICHRA) Plan, Gallagher may suspend all or a portion of its Services if the Plan Sponsor has failed to remit required contributions with sufficient, good, and available funds by the deadline and via the method of delivery agreed upon in the Onboarding and Renewal Summary, and fails to remit such past due contributions within ten (10) days following delivery by Gallagher of Official Notice that such funds are past due. The suspension of Services shall continue until the Plan Sponsor remits sufficient, good, and available funds via the agreed-to method of delivery.

(c) Termination for Convenience. Gallagher may resign and terminate this Agreement or any ASA with or without cause at any time by giving Official Notice to the Plan Sponsor at least ninety (90) days before such resignation is to become effective, unless such notice is waived by the Plan Sponsor. The Plan Sponsor may remove Gallagher and terminate this Agreement or any ASA, with or without cause, by giving Official Notice to Gallagher at least ninety (90) days before such removal is to become effective, unless such notice is waived by Gallagher.

(d) Termination for Cause.

- (i) Upon ten (10) days prior Official Notice, either party hereto may terminate this Agreement or any ASA for cause due to a material default of the other party that has occurred and continued without cure for at least 30 days following receipt of Official Notice of the material default from the other party. A “material default” with respect to either party shall include but is not limited to the breach of or failure of that party (the “breaching party”) to perform any of its obligations under this Agreement if the other party (the “non-breaching party”) reasonably determines that such breach or failure has a material and adverse effect on the non-breaching party or a material and adverse effect on the applicable Benefit Plan or the operation or administration of the Benefit Plan.
 - (ii) In addition to the suspension right set forth in subsection (b) and the termination rights set forth in subsections (c) and (d)(i) of this Section, Gallagher shall have the right to terminate this Agreement or any ASA, effective upon delivery of Official Notice, in the event that: (1) Gallagher has, pursuant to subsection (b) of this Section, suspended Services at least twice during any plan year or suspended services for a single consecutive period longer than sixty (60) days; or (2) the Plan Sponsor has failed to timely pay Compensation and Expenses and/or Regulatory Fees or Expenses as set forth in this Agreement or any ASA within thirty (30) days following delivery by Gallagher of Official Notice that such fees are past due.
- (e) No Liability for Prior or Successor Service Provider. Gallagher shall not be liable for the acts or omissions of any prior administrator or service provider or for any entity who succeeds Gallagher as the HealthInvest Service Manager or otherwise providing one or more services similar to the Services provided by Gallagher (“Successor Service Provider”).
- (f) Wind Down. In connection with any termination of this Agreement and all ASAs by either party hereto:
- (i) Gallagher will use best efforts to cooperate with the Plan Sponsor or Successor Service Provider to accomplish an orderly transition of business and, on or before the termination date, transfer of functions, books, records, documentation, data, monies and other plan assets. Prior to the termination date, Gallagher will provide all necessary staff, services, and assistance required for such orderly transfer, including participation by appropriate personnel in periodic conference calls to effect a smooth transition.
 - (ii) Following any termination of this Agreement, Gallagher will: (1) maintain all participant-level paperwork and documentation as provided in Section 10 hereof and, upon request and at the Plan Sponsor’s expense, deliver or make-available to the Plan Sponsor all or any portion of such paperwork and documentation in a manner reasonably acceptable to Plan Sponsor; and (2) cooperate and assist with any audit, examination, review, or inspection of the Plan Sponsor’s Benefit Plan for which Gallagher is maintaining records, subject to Gallagher’s right to charge reasonable hourly fees and expenses for these services to the extent the assistance requires Gallagher to expend material time or resources.
 - (iii) With respect to any Participant Accounts established in connection with an ICHRA Plan with a remaining balance at the time of termination of Services with respect to the ICHRA Plan, the Plan Sponsor will have the option, in lieu of transitioning to a Successor Service Provider, to continue Post-termination Services under this

Agreement as described herein and in the ASA for HRA Services, solely for the purpose of maintaining (1) minimum administration required for such Participant Accounts in accordance with the Plan Documents and (2) any applicable regulatory compliance for the Plan and the Plan Sponsor Trust until all remaining balances have been distributed in full according to the terms of the Plan and Trust Documents. Continuation of Post-termination Services are conditioned upon the Plan Sponsor's timely payment of the Compensation and Expenses for Post-Termination Services in effect as of the termination date (as set forth in the ASA for HRA Services), the nonpayment of which will be subject to termination for cause pursuant to subsection (d) of this Section.

12. Updating and Delivery of Plan Information; Reliance on Information.

(a) Specific terms of each Plan, including the Plan Effective Date, Plan Year, the class or classes of employees to be covered by the Plan, waiting periods, carry-over and grace period features, and the contribution policies for each class of employees, etc., are specified in a "Plan Information Summary," which is a component of the "Summary Plan Description" or "SPD" for each of the Plan Sponsor's Benefit Plans and any Participating Employer's Benefit Plans. The Plan Sponsor agrees that, annually, and otherwise upon the reasonable request from Gallagher, the Plan Sponsor and any Participating Employer will update its Onboarding and Renewal Summary or otherwise provide Gallagher with updates to its plan design terms or elections and information required to be included in its Plan Information Summary for each Plan or other information requested by Gallagher to assist Gallagher in the performance of the Services. The Plan Sponsor hereby directs Gallagher to update the Plan Information Summary and SPD on an annual basis and as otherwise required by law based upon the updated information provided by the Plan Sponsor to Gallagher.

(b) The Plan Sponsor understands that from time to time, enrollment materials relating to the Plan Sponsor's Benefit Plan will be provided by Gallagher electronically or in printed packets at onsite enrollment and educational meetings. The Plan Sponsor agrees to use its best efforts to ensure that eligible employees receive these printed materials whether or not they attend these meetings and to communicate to Gallagher if the Plan Sponsor has been unable to deliver the enrollment materials to any employee.

(c) In the performance of its Services hereunder and under the Plan Documents, Gallagher shall have the right to rely on the Onboarding and Renewal Summary and other information provided by the Plan Sponsor and any Participating Employer with respect to any policies or contractual obligations relating to, among other things, employee eligibility and contribution funding policies and shall have no obligation to confirm the Plan Sponsor's or Participating Employer's compliance with such agreements, contracts, or policies or whether such agreements, contracts, or policies comply with applicable law.

13. Indemnification and Liability.

(a) Gallagher Indemnification Obligations. Gallagher hereby agrees to defend, indemnify, and hold harmless the Plan Sponsor and its affiliates, agents, and sub-contractors, and each of their officers, employees, successors, and assigns against any and all costs, losses, damages, expenses, and charges, including reasonable court costs and attorneys' fees and costs (collectively, "Losses"), resulting from any claim, cause of action, judgment, or liability of any nature by a third party (including a Participant) (collectively, "Claim" or "Claims") arising out of Gallagher's material breach of or failure to perform its obligations under this Agreement or the

Plan Documents or such other act or omission that is outside the scope of Gallagher's authority under this Agreement or the Plan Documents (unless such act or omission is at the direction of or authorized by the Plan Sponsor, Participating Employer, or Administrator) but only to the extent such breach, act, or omission is the result of the gross negligence, willful misconduct, or illegal acts of Gallagher.

(b) Plan Sponsor's Indemnification Obligations. Plan Sponsor hereby agrees to defend, indemnify, and hold harmless Gallagher and its affiliates, agents, and sub-contractors, and each of their officers, employees, successors, and assigns against any and all Losses resulting from any Claim arising out of: (i) the Plan Sponsor's, Participating Employer's or Administrator's material breach of or failure to perform its obligations under this Agreement, the Benefit Plans, or the Plan Documents, or other act or omission by Plan Sponsor, Participating Employer, or Administrator in connection with any Plan, but only to the extent such breach, act, or omission is the result of the gross negligence, willful misconduct, or illegal acts of the Plan Sponsor, Participating Employer, or Administrator, as applicable; (ii) the Plan Sponsor's, Participating Employer's or Administrator's (A) contest of or failure or refusal to pay any Governmental Assessment or to reimburse Gallagher for its payment of any Governmental Assessment applicable to the Benefit Plans or the Plan Sponsor or such Participating Employer that is required by law to be assessed and or paid by Gallagher as the HealthInvest Service Manager for the Benefit Plans or (B) failure or refusal to timely or sufficiently fund contributions under the Benefit Plans in accordance with the terms and conditions of the Benefit Plans, contractual agreements, collective bargaining, employer policy, or otherwise; (iii) provision or granting of credentials to access the Plan Sponsor's online employer/plan sponsor portal account to individuals or entities who are not authorized employees of the Plan Sponsor; or (iv) any act or omission of Gallagher undertaken pursuant to the direction or authorization of the Plan Sponsor, Participating Employer, or Administrator, or their designees, agents, or employees in the exercise of such party's discretionary authority; (iv) any non-discrimination testing performed at the election of the Plan Sponsor or a contribution funding method determined by the IRS to violate applicable non-discrimination rules; or (v) the actions or omissions of any Successor Service Provider or prior third-party administrator or service provider providing one or more similar services to the Benefit Plans as provided by Gallagher.

(c) Indemnification Procedure. Each indemnified party shall provide the indemnifying party with prompt Official Notice of any Claim for which the indemnified party is seeking or may seek indemnification hereunder; provided that the failure of the indemnified party to promptly notify the indemnifying party hereunder shall not relieve the indemnifying party of any liability with respect to the Claim, except to the extent the indemnifying party demonstrates that the defense of the Claim is prejudiced by such failure. The indemnified party shall provide reasonable cooperation (at the indemnifying party's expense) and full authority of the indemnifying party to defend or settle the Claim. The indemnifying party shall keep the indemnified party fully informed concerning the status of any litigation, negotiations or settlements of any Claim. The indemnified party shall be entitled, at its own expense, to participate in any action with counsel of its own choosing. The indemnifying party shall not have the right to settle any Claim if such settlement arises from or is part of any criminal action or proceeding, or contains a stipulation to, or an admission or acknowledgement of, any wrongdoing (whether in tort or otherwise) on the part of the indemnified party, without the prior written consent of such indemnified party.

(d) General Limitation on Liability. Except as specifically provided in paragraphs (e) and (f) of this Section, neither party shall be liable for: (i) consequential, indirect, incidental, special, exemplary, punitive or enhanced damages, lost profits or revenues, or diminution in value,

regardless of whether based on contract, tort, strict liability or otherwise or whether such damages were foreseeable or the party liable was advised of the possibility of such damages; or (ii) damages in excess of \$1,000,000 in the aggregate. This provision applies to the fullest extent permitted by applicable law.

(e) **Liability for Unauthorized Disclosures.** With respect to liability resulting from an unauthorized use or disclosure of protected health information or other personally identifiable information or data protected by state or federal law, in no event will Gallagher be liable for any damages in excess of \$2,000,000 in the aggregate.

(f) **Force Majeure.** Except for the Plan Sponsor's obligation to pay Compensation and Expenses to Gallagher pursuant to Section 5, neither party will be liable for any failure or delay in the performance of its obligations hereunder by reason of any event or circumstance beyond its reasonable control, including but not limited to acts of God, war, riot, strike, labor disturbance, fire, explosion, telephone or internet network failure, flood, pandemic, epidemic, public health emergency, communicable disease outbreak (or any governmental order or regulation issued in connection therewith), or other reason of like nature not the fault of the party delayed.

14. Rules, Policies, and Procedures. The Plan Sponsor hereby adopts and establishes such rules, policies and procedures as are set forth in the Plan Documents or other forms, literature, and educational materials for the HealthInvest Benefit Plans of the Plan Sponsor covered by this Agreement. To the extent not set forth in the Plan Documents or this Agreement, the Plan Sponsor hereby authorizes and directs Gallagher to establish such rules and procedures as it deems appropriate to provide the Services in accordance with this Agreement, the Plan Documents, and the direction of the Plan Sponsor, all of which shall be binding upon the Plan Sponsor, Administrator, Participating Employers, Participants, and other individuals who may be entitled to benefits under the Benefit Plans.

15. No Legal or Tax Advice. The Plan Sponsor acknowledges and agrees that Gallagher is neither a legal nor tax advisor, nor shall be construed as having provided legal or tax advice, to the Benefit Plans, the Plan Sponsor, Administrator, any Participating Employer, or Participant. The Plan Sponsor acknowledges and agrees that it is responsible for consulting with its own legal counsel, financial advisors, and tax professionals regarding the operations and administration of the Benefit Plans, and the Benefit Plans' compliance with applicable laws and regulations and the tax exemption or tax deductibility of contributions to any Benefit Plan or the tax exemption of any earnings on plan assets under or benefits paid out of or under any Benefit Plan.

16. Construction and Interpretation of this Agreement; Conflicts.

(a) Headings used in this Agreement and any Appendix hereto are inserted for convenience of reference only and are not to be used in interpreting the provisions. Unless expressly noted otherwise, references to or definition of (i) any document, instrument, or agreement (ii) policy or procedure established, approved, or adopted by a party or (iii) any federal or state statute, regulation, administrative decision, ruling, rule, guidance, or order, shall mean the same as amended, restated, supplemented, or otherwise modified from time to time. The words "including," "includes," and "include" are used to mean without limitation. The word "or" is not exclusive. Wherever from the context it appears appropriate, each term stated in either the singular or plural shall include the singular and the plural, and pronouns stated for convenience in a specific gender (e.g., masculine, feminine, or neuter gender) are intended to include all genders.

(b) In the event of any conflict between the provisions of this MSA and one or more of the Appendices hereto, the conflict shall be resolved first by reference to the applicable Appendix, then to this MSA.

17. HIPAA Requirements and Certification; Applicability of State Laws; and Applicability of Nondiscrimination Rules; Authorized Representative for Regulatory Filings; ERISA Bond.

(a) Application of HIPAA. Plan Sponsor acknowledges that each Plan is a “Covered Entity” and meets the definition of a “Health Plan,” as such terms are defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the regulations thereunder (“HIPAA Regulations”). As a condition to Gallagher’s execution of this Agreement, the Plan Sponsor and Gallagher have executed a HIPAA Business Associate Agreement (“BAA”) and agree to execute any amendments thereto or replacements thereof as required by law. Gallagher may unilaterally amend the BAA in order to comply with applicable law, but only to the extent such applicable law (i) imposes obligations on Gallagher, as a business associate under HIPAA, that are not covered by the BAA and (ii) requires such additional obligations to be covered by the terms of the BAA. Plan Sponsor and Participating Employers may be required to adopt certain policies and procedures on behalf of the Benefit Plans that are prescribed by HIPAA and the HIPAA Regulations. Plan Sponsor accepts responsibility for compliance with HIPAA and the HIPAA Regulations for itself and on behalf of any Participating Employers. The Plan Sponsor hereby acknowledges that the Plan Documents incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) regarding provisions required to be included in the Plan Documents, and the Plan Sponsor hereby agrees to the conditions of disclosure described therein.

(b) HIPAA Compliance Certificate. The Plan Sponsor may, pursuant to the terms of the Plan Documents, request and receive certain participant data that is considered by the Plan to be protected health information (PHI) under HIPAA. Upon receipt of an executed HIPAA Compliance Certificate attached hereto as Addendum A, the Plan may share requested PHI with the Participating Employer or Plan Sponsor, so long as it will be used by the Participating Employer or Plan Sponsor exclusively for Plan administration functions, and Plan Sponsor certifies it will and will cause each Participating Employer to take the steps specified in the applicable Plan Document to protect such PHI.

(c) Applicability of State Law. Plan Sponsor acknowledges that various state laws applicable to the Plan, Plan Sponsor, or Participating Employers may affect certain aspects of the Plan or the Plan Sponsor’s or a Participating Employer’s ability to adopt the Benefit Plans. These may include, without limitation, state laws regarding the investment of public funds, the permissibility of the Plan Sponsor or Participating Employer to act as a trustee or fiduciary, conflicts with other statutory or state-sponsored plans, state agency reporting requirements, and the applicability of state income taxes. Plan Sponsor and any Participating Employer should seek the advice of its own legal or tax counsel for such state-law issues.

(d) Non-discrimination Rules. Plan Sponsor acknowledges that one or more federal and state laws and regulations prescribe non-discrimination rules for each Plan with respect to eligibility for, contributions to, and benefits under each Plan, and assets held in trust with respect to each Plan, including without limitation §§ 105(h) and 505(b) of the Internal Revenue Code of 1986, as applicable. While Gallagher may assist the Plan Sponsor in designing its Benefit Plans to comply with these rules, Plan Sponsor acknowledges that neither Gallagher, nor any of its affiliates, sub-contractors, agents, representatives, officers, or employees accepts any

responsibility for Plan Sponsor's compliance with §105(h), §505(b) or such other nondiscrimination laws and that the Plan Sponsor will review its collective bargaining agreements and eligibility and contribution policies with its own legal and tax counsel to confirm compliance with these legal requirements. Toward that end, Plan Sponsor assumes all risk of tax liability associated with contribution funding that is determined to discriminate in favor of highly compensated employees.

(e) Authorized Representative for Regulatory Filings. As part of the Services under one or more ASAs, Gallagher will make or file regulatory filings, reports, payments or applications, including applications for tax exemption or other regulatory exemptions or approvals on behalf of the plan or any trust established to hold plan assets ("Regulatory Filings") on behalf of the Benefit Plans or the Plan Sponsor. In some cases, applicable law requires that Regulatory Filings be made by the Plan Sponsor, including without limitation, submission and payment the Patient Centered Outcomes Research Institution Fee via Internal Revenue Service ("IRS") Form 720 and submission of an application for tax exemption of a voluntary employees' beneficiary association ("VEBA") trust via IRS Form 1024. The Plan Sponsor desires that Gallagher facilitate Regulatory Filings on behalf of the Plan and the Plan Sponsor, and the Plan Sponsor hereby appoints Gallagher as its authorized representative to execute and submit Regulatory Filings on its behalf to the extent applicable law requires any Regulatory filings be made or submitted by the Plan Sponsor. The Plan Sponsor agrees to execute IRS Form 2848 (Power of Attorney and Declaration of Representative) or such other powers of attorney as may be required by any regulatory authority in order to facilitate Gallagher's ability to execute and submit Regulatory Filings on behalf of the Plan Sponsor. Gallagher's appointment as an authorized representative of the Plan Sponsor for Regulatory Filings is subject to the Plan Sponsor's right to remove and Gallagher's right to resign as provided herein.

(f) ERISA Bond. With respect to funded HRA and funded ICHRA Plans that are subject to ERISA, Gallagher will cause any subcontractors that "handle" plan assets (as defined by ERISA) to maintain an ERISA fidelity bond in amounts required by ERISA as part of its Services included under the ASA for HRA Services. The Plan Sponsor shall seek advice of its own legal counsel as to whether the Plan Sponsor or the Plan Administrator (if other than the Plan Sponsor) or any of their employees, representatives, agents, or designees with respect to administration of the Plan, are required to obtain a separate ERISA fidelity bond with respect to its Plan.

18. Plan Sponsor Obligations and Responsibilities.

(a) Plan Sponsor and Plan Administrator Performance. Plan Sponsor acknowledges and agrees that certain obligations and responsibilities of Plan Sponsor under this Agreement and the Plan Documents will be performed by the Plan Administrator. Plan Sponsor will ensure that the Plan Administrator complies with all of its obligations under this Agreement and the Plan Documents and will be directly responsible for all performance by the Plan Administrator. Plan Sponsor agrees and acknowledges that successful performance of the Services by Gallagher and ongoing operation and administration of the Benefit Plans is dependent on Plan Sponsor and/or Plan Administrator's reasonable cooperation. Accordingly, Plan Sponsor shall allocate appropriate personnel and resources to work with Gallagher, as needed.

(b) Responsibility for Cost and Expenses of the Benefit Plans. Plan Sponsor shall have the sole and full financial responsibility and liability for all funding requirements of the Benefit Plans and benefits provided under the Benefit Plans, including but not limited to (i) all required contributions, whether based on contractual agreements, collective bargaining, employer

policy, or otherwise, (ii) Compensation and Expenses associated with the Services and services provided by other service providers to the Benefit Plans engaged directly by Plan Sponsor or the Plan Administrator, (iii) any Governmental Assessments that might be imposed relating to the Benefit Plans, and (iv) the cost and expenses associated with any financial audit that is required for the Plan or Plan Sponsor Trust (under Form 5500 or otherwise).

(c) Plan Sponsor Contribution Funding Obligations for Individual Coverage HRA and Flexible Spending Account Services. If the Plan Sponsor is offering an Individual Coverage HRA under the ASA for HRA Services or a Flexible Spending Account under the ASA for Salary Reduction Plan Services, the Plan Sponsor acknowledges and agrees that it has engaged Gallagher to handle on the Plan Sponsor's behalf the administration of employer contributions, employee salary reduction elections, and the payment or reimbursement of qualified expenses, including monthly premiums for individual or group insurance coverage. To ensure the timely funding of its contribution obligations under these Benefit Plans, and as a condition to Gallagher entering into this Agreement, the Plan Sponsor is executing the ACH Authorization Form delivered to and approved by the Plan Sponsor in connection with its engagement of Gallagher in which the Plan Sponsor designates one or more banking or other depository accounts ("Depository Accounts") from which the Plan Sponsor will fund its contribution obligations under the Benefit Plans. Plan Sponsor further agrees to execute any additional, alternate, or replacement ACH Authorization Forms that may be applicable from time to time in the event of a change to or designation of additional Depository Accounts for purposes of funding its contribution obligations or paying Compensation and Expenses to Gallagher. Plan Sponsor will ensure that the designated Depository Accounts have sufficient funds to fund the Plan Sponsor's contribution obligations within the deadlines communicated to the Plan Sponsor or will provide funds to Gallagher within two (2) business days of notification from Gallagher that there were insufficient funds in the Accounts. Notwithstanding the foregoing, Plan Sponsor acknowledges that Gallagher is not an insurer or underwriter of any portion of the Benefit Plans, other than its own cost to provide the Services, nor is Gallagher responsible or liable for costs to pay premiums for individual or group insurance coverage to be funded through the Benefit Plans, reimbursements for other qualified out-of-pocket medical expenses, or any other costs associated with administration of the Benefit Plans. The Plan Sponsor will indemnify and hold Gallagher harmless in accordance with Section 13(b) hereof for any claims against or Losses incurred by Gallagher as a result of the Plan Sponsor's failure to fund its contribution obligations, including claims or Losses arising out of termination of individual or group coverage as a result of the Plan Sponsor's failure to fund its contribution obligations under the Benefit Plans. Any additional assistance or work performed by Gallagher that arises directly from termination of individual or group insurance coverage due to non-payment arising directly from the Plan Sponsor's failure to fund its contribution obligations is not included in the standard Compensation and Expenses and will be billed to the Plan Sponsor based on reasonable hourly rates.

(d) Providing Portal Access to or Sharing of Plan Data or PHI with Third Parties. Plan Sponsor shall limit access to its online employer/plan sponsor portal account to only authorized personnel employed by the Plan Sponsor who need such access for proper administration of its Plan. Plan Sponsor assumes responsibility and liability for any risk associated with providing or granting online employer/plan sponsor portal account access to unauthorized personnel or third parties (such as benefits consultants, brokers or financial advisors) to assist the Plan Sponsor with administration of its Plan, and agrees that any Claim against Gallagher or Loss incurred by Gallagher in connection with such unauthorized personnel or third party online portal account access is subject to the Plan Sponsor's indemnification obligations under Section 13(b).

19. Official Notices. Unless otherwise provided herein, whenever any Official Notice is required or permitted to be given under this Agreement, such notice shall be in writing and shall be deemed to have been duly given, received and effective on (i) the date of receipt if delivered personally, (ii) three (3) business days after the date of posting if transmitted by mail, (iii) the business day after the date of transmission if by overnight delivery with proof of delivery, or (iv) the date of delivery if by electronic mail; provided that, notice by electronic mail shall not be deemed given if the deliverer receives a notice that the electronic mail was undeliverable or any other indication that delivery of the electronic mail failed. In all cases the Official Notice shall be addressed to the applicable Party as set forth below:

(a) The address for delivery of all communications to the Plan Sponsor or a Participating Employer will be provided by the Plan Sponsor and updated as provided under Section 9.

(b) The address for delivery of all communications to Gallagher shall be:

By mail to: Attn: Official Notices
HealthInvest HRA
221 N Wall Street, Suite 201
Spokane, WA 99201

Or by email to: britt_afdem@ajg.com

20. Entire Agreement.

(a) Except for (1) the HIPAA Business Associate Agreement executed in connection herewith and (2) any Procurement Contract described in subsection (b) below, this Agreement and the Onboarding and Renewal Summary constitute the complete agreement of the parties regarding the subject matter hereof and replaces and supersedes any prior written or oral agreement between the parties regarding its subject matter. No representations or warranties have been provided by any party to this Agreement to any other party to this Agreement except as specifically set forth in this Agreement.

(b) If the Plan Sponsor and Gallagher have entered into a separate written agreement governing the terms and conditions of Gallagher's Services or pursuant to the terms of a request for proposal or Gallagher's response thereto, such agreement (the "Procurement Contract"), shall be attached hereto as Addendum B. In the event of a conflict between this Agreement and the Procurement Contract, the terms of the Procurement Contract, at the election of either the Plan Sponsor or Gallagher, shall control.

21. Amendments.

(a) Except as specifically provided in Sections 3, 5 and 6 (with respect to updates to the Onboarding and Renewal Summary, changes in fees and expenses, or the expansion, improvement or addition of new Services by Gallagher), or as provided in subsection (b) of this Section, this Agreement may be amended with written approval by the Plan Sponsor and Gallagher. Any amendment to this Agreement or any Plan and Trust Document may be given retroactive effect if such retroactive effect is required or permitted by applicable law.

(b) In order to provide the Services effectively for the Plan Sponsor and other plan sponsors and employers who utilize Gallagher's services and proprietary Plan Documents, the Plan

Sponsor agrees that in addition to the foregoing manner of amending this Agreement in subsection (a), this Agreement and any Plan Documents may be amended or restated in the manner set forth herein and consistent with U.S. Department of Labor Advisory Opinion 97-16A as described below:

Gallagher may propose to modify or amend and restate this Agreement or any Plan Document by giving the Plan Sponsor Official Notice not less than sixty (60) days prior to the effective date of the proposed amendment. The notice shall be given in the manner prescribed for delivery of Official Notices in Section 19 of this Agreement. The notice will: (1) explain the proposed change; (2) fully disclose changes in the fees, if any, to be charged as a result of any proposed change; (3) identify the effective date of the change; (4) explain the Plan Sponsor's right to reject the change or terminate the services of Gallagher under this Agreement; and (5) state that pursuant to the provisions of this Agreement, if the Plan Sponsor does not object to the proposed change before the date on which the change become effective, the Plan Sponsor will be deemed to have consented to the proposed change. If the Plan Sponsor objects to the proposed change, the Plan Sponsor shall submit Official Notice of its objection at least thirty (30) from receipt from Gallagher of the proposed change. If the Plan Sponsor has objected to the change, and if on or before the effective date of the proposed change, the Plan Sponsor and Gallagher have not reached agreement with respect to the proposed change, the proposed change shall not become effective, and the Plan Sponsor's objection to the proposed change shall be subject to the Plan Sponsor's right to remove Gallagher and Gallagher's right to resign as provided in this Agreement.

22. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall constitute an original, and all of which together will constitute one and the same agreement. Facsimile delivery transmission or electronic delivery in portable document formation (".pdf") or tagged image formation (".tiff") by any party hereto of its executed counterpart shall constitute the valid and binding execution hereof by such party. The Plan Sponsor and Gallagher agree that electronic signatures constitute a valid and binding execution by the party electronically signing this Agreement.

23. Assignability. This Agreement calls for the personal services of Gallagher and for certain financial and other specified obligations of Plan Sponsor. Gallagher shall not assign its rights or obligations hereunder without the prior written consent of the Plan Sponsor. The Plan Sponsor shall not assign its rights or obligations hereunder without the prior written consent of Gallagher. Notwithstanding the foregoing, Gallagher shall have the right, without the prior consent of the Plan Sponsor, to assign this Agreement to any successor to all or substantially all of its assets and business by dissolution, acquisition, merger, consolidation, transfer of assets, change or conversion of entity type, or otherwise, or to any entity that has ownership control over Gallagher.

24. Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and each of their respective successors and assigns to the extent permitted hereby.

25. Survival. The provisions of this Agreement, which by their nature survive expiration or termination of this Agreement, shall survive. Any remedies for material breach of this Agreement shall also survive any termination or expiration.

26. Governing Law; Jurisdiction. This MSA shall in all respects be interpreted, enforced and governed in and under the laws of the state of domicile of the Plan Sponsor, without

reference to choice of law principles. Should any provision of this Agreement be declared or determined by any court to be illegal or invalid, the validity of the remaining parts shall not be affected thereby, and the illegal or invalid part shall be deemed not to be a part of this Agreement. Any dispute arising under or in connection with this Agreement shall be subject to the exclusive jurisdiction of the state or federal courts located in Washington.

IN WITNESS WHEREOF, the Plan Sponsor and Gallagher hereby execute and deliver this Agreement, as evidenced by the signature below of an authorized officer or representative thereof and shall be effective as of the Effective Date set forth in the introduction to this Agreement notwithstanding the date of execution by each of the parties.

Plan Sponsor
Renton Regional Fire Authority

By: _____
authorized signatory

Printed Name: Steven C. Heitman

Title: Fire Chief

Dated: September 14, 2026

HealthInvest Service Manager
Gallagher Benefit Services, Inc.

By: _____
authorized signatory

Printed Name: _____

Title: _____

Dated: _____

ADDENDUM A

HIPAA Compliance Certificate

Following this page is the executed HIPAA Compliance Certificate of the Plan Sponsor.

HIPAA COMPLIANCE CERTIFICATE

This HIPAA Compliance Certificate is hereby delivered pursuant to the requirements of the HealthInvest Plan Documents, as amended by the HIPAA Plan Amendment set forth therein. Capitalized terms used herein and not otherwise defined herein shall have the meanings set forth for such terms in the Plan Documents.

The undersigned hereby represents that he or she is authorized to execute this HIPAA Compliance Certificate on behalf of the Plan Sponsor named below. The Plan Sponsor named below has requested that the Plan deliver protected health information (“PHI”) or Electronic PHI to the Plan Sponsor or Employer in order for the Plan Sponsor or Employer to use such information solely for Plan administration functions. The Plan Sponsor and Employer shall allow access to the PHI only to those employee positions responsible for Plan administration and who have been properly trained to comply with the HIPAA Privacy and Security Rules.

The Plan Sponsor hereby acknowledges and agrees that the Plan incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in the Plan Document, and all other conditions and requirements of HIPAA.

This HIPAA Compliance Certificate is executed on the date set forth below on behalf of and with the authority of the Plan Sponsor named below:

Plan Sponsor:

Renton Regional Fire Authority

By: _____

Name: Steven C. Heitman

Title: Fire Chief

Date: September 14, 2026

HealthInvest
ADMINISTRATIVE SERVICES APPENDIX
for Salary Reduction Plan Services

Premium Only Plan / Health FSA / Dependent Care FSA

This Administrative Services Appendix for Salary Reduction Plan Services (this “Salary Reduction Plan ASA” or this “ASA”) is incorporated into and made a part of the Master Services Agreement (“MSA”) entered into by and between Gallagher Benefit Services, Inc. (“Gallagher”), a Delaware corporation, in its capacity as the Service Manager under the HealthInvest Plan Documents (the “Service Manager”), the Plan Sponsor who is a party thereto. This ASA is effective as of the date the Plan Sponsor elects the Services covered by this ASA pursuant to an Onboarding and Renewal Summary delivered or approved in writing or electronically by the Plan Sponsor.

1. Services.

(a) The Services for salary reduction plan (or cafeteria plan) administration covered by the MSA and this ASA shall include administrative services for any of the below Benefit Plans or pretax benefit options elected to be offered by the Plan Sponsor through its Salary Reduction Plan pursuant to an Onboarding and Renewal Summary:

Premium Only Plan (POP)*
Health Flexible Spending Account (FSA)
Dependent Care FSA
Health Savings Account**

**This is a mandatory benefit offering if the Plan Sponsor is offering the HealthInvest ICHRA Benefit Plan.
** Available only if Gallagher is engaged to provide HSA Services under the ASA for HSA Services.*

(b) With respect to the Benefit Plans elected by the Plan Sponsor to be covered by this ASA, the following services are included, as the same may be amended from time to time in accordance with the MSA. Services related to an HSA benefit option offered through the Plan Sponsor’s Salary Reduction Plan are covered in the ASA for HSA Services.

1) Web Portal and Mobile Application:

- Maintain web portal for the benefit of Participants and Plan Sponsor.
- Maintain a mobile application for participants.

2) Plan Design and Adoption:

- Assist the Plan Sponsor with plan design elections and completion of Onboarding and Renewal Summary and other onboarding materials.
- Provide Plan Sponsor with plan adoption/welcome package after execution of MSA and receipt of a completed Adoption Agreement.
- Set up any applicable grace period, run-out period, or carryover as provided in the Plan Documents and in accordance with applicable law.

3) Eligibility and Enrollment Management:

- Enter eligibility information at the employer level.
- Set-up new FSA participant accounts (health and/or dependent care, as

applicable) during the enrollment period using enrollment upload file (census enrollment) and employer plan design information (new hires starting during plan year may enroll via an enrollment form).

- Administer election changes at Employer or Plan Administrator direction (qualified life event changes will be accepted only from the Plan Administrator).

4) Contribution Funding:

- As elected by Plan Sponsor, manage funding of contributions using one of the funding methods permitted by Gallagher.
- Monitor Plan Sponsor's reserve requirement and communicate to Plan Sponsor any additional funding amount required to secure Plan Sponsor's obligation to pay traditional claims or debit card transactions.

5) Forms and Documents:

- Provide, update, maintain, and distribute in accordance with applicable law all Plan Documents, including any Summary Plan Description and Summary of Material Modifications
- Develop, update, and maintain all plan forms (including, but not limited to, enrollment forms, claim forms, election forms, etc.) necessary for the operation and administration of the Plan in accordance with the Plan Documents.
- Develop, update, and maintain all plan literature and other information necessary or as agreed upon to support employer and employee education.

6) Customer Support:

- Provide customer service and assistance to Participants regarding education and enrollment, Plan benefits, website and other Plan questions and assistance regarding benefit accounts.
- A toll-free number will be made available between the hours of 9:00 am – 8:00 pm ET Monday through Friday (except holidays and other scheduled downtime).
- Provide technical, compliance, and educational support to the Plan Sponsor and Participating Employers and Participants.

7) Benefit Card Services:

- Make a benefit card program available for all employees enrolled in the Plan to be used by cardholders to pay for eligible expenses in accordance with applicable law.

8) Claim Reimbursement:

- Provide claim reimbursement by check or direct deposit as elected by the participant.
- Accept claims electronically via the portal, mobile application, or by paper via a claim form. Only claims submitted in accordance with the instructions set forth on Gallagher's claim forms will be processed.
- Process claims, claim denials, and appeals in accordance with applicable law.
- Make reasonable attempts to request repayment of overpaid claims or unsubstantiated debit card payments or offset the ineligible payment against any claims for future eligible expenses in accordance with the Plan Documents and applicable rules and regulations.

- Claims reimbursement services include determination if a receipt is valid and covers a qualified expense under IRC § 213(d), and delivery of all applicable notices required in the Plan Document. Any determination on formal appeal requiring discretion must be approved in writing by the Administrator.

9) Recordkeeping:

- Provide recordkeeping services for Participant and Employer Accounts.
- Maintain and provide access to all records received, maintained, or created by Gallagher relative to the Plan as needed for Plan audits.
- Assist with the investigation of errors reported to the Plan by a Plan Sponsor, Employer, or Participant.

10) Plan Operation and Compliance:

- Operate the plan in compliance with all federal laws and regulations applicable to the Plan and any trust used to fund plan assets.
- Draft, create, and make any changes to Plan documents, Plan forms, Plan materials, Plan literature, and Plan policies and procedures as are routine, desirable, or necessary to improve the efficiency and effectiveness of the operation of the Plan, to clarify ambiguities for the benefit of the Administrator, Plan Sponsor, or eligible Participants, and to comply with applicable legal requirements.
- Provide reasonable assistance and services necessary to obtain or make all necessary regulatory or other governmental filings, registrations and approvals for this Plan and facilitate payment of applicable Governmental Assessment.
- Assist with communication between and coordinate the activities of subcontractors and service providers to the Plan.
- Facilitate payment of operating expenses of the Plan in accordance with the Plan Documents and direction of the Administrator.
- Recommend and implement operational and compliance practices and procedures for the effective, efficient, and compliant operation of the Plan.

11) Communication:

- Draft periodic Plan Sponsor and/or Participating Employer and Participant communications regarding legal and compliance updates, participant rights and responsibilities, and reminders regarding Plan benefits, policies, and procedures, etc.
- Prepare and deliver notices and documents to Participants and Plan Sponsor and /or Participating Employers, as necessary, desirable, required by law, or as otherwise agreed.

12) Reporting and Audit Support:

- Provide Plan Sponsor with contribution and participant information from which Plan Sponsor will be able to complete and file any applicable filings or reports.
- Provide standard reporting and agreed-upon custom reporting.
- Provide reasonable assistance with regulatory audits applicable to the Plans.

13) Application of Forfeitures (or Experience Gains):

- At the election of Plan Sponsor and to the extent permitted by ERISA (if applicable) and other applicable law, at the end of the plan year, Gallagher will

apply funds in the following order: to offset experience losses of the Plan and to offset any fees as permitted by law. Then Gallagher will apply any remaining funds as elected by Plan Sponsor either to: (1) contributions for future plan years; (2) pay Plan administrative expenses; or (3) if permitted by law, back to Plan Sponsor via check or ACH.

14) Non-Discrimination Testing:

- As elected by Plan Sponsor on an annual basis, conduct nondiscrimination testing (NDT) for any HealthInvest Benefit Plan covered by this ASA to the extent required by Internal Revenue Code.

15) COBRA Administration (optional and limited to Special Limited COBRA Obligation):

- Prepare and deliver all notices required under COBRA.
- Provide written and/or electronic means for Plan Sponsor, Participating Employers, Participants, and other COBRA beneficiaries to provide notice of COBRA qualifying events and to elect COBRA as required by law.
- Administer Special Limited COBRA Obligation applicable for health FSAs.

2. Compensation and Expenses. The Plan Sponsor accepts and agrees to the Compensation and Expenses for the Services applicable under this ASA as set forth in the Pricing Appendix, as the same may be amended from time to time in accordance with the MSA.

3. Plan Sponsor Obligations and Responsibilities.

(a) Plan Sponsor Reimbursement Obligations. Plan Sponsor has engaged Gallagher to handle the administration and payment of Plan claims on Plan Sponsor's behalf. Plan Sponsor and or Employer may elect to fund its reimbursement obligations under the Plan from its general assets, based on advanced funding and automated electronic payment requirements of the Plan. All ongoing funding required during the plan year will be based upon participant claims spend, and not tied to the Employer's payroll cycle. All funding of Plan Sponsor's reimbursement obligations under the Plan is due upon demand by Gallagher and will be pulled automatically per the ACH Authorization on file with HealthInvest. The Employer is responsible for assuring there are sufficient funds available in the applicable account(s) at the time of each permitted electronic payment. In any case, funds received by Gallagher shall not be considered trust funds and are not held by Gallagher or segregated by Plan Sponsor or Gallagher on behalf of the Plan or Plan participants.

(b) Plan Sponsor Reserve Obligations. Plan Sponsor agrees to provide funds to Gallagher from its general assets to maintain a reserve to secure Plan Sponsor's obligation to pay claims and to reimburse Gallagher or the debit card BIN sponsor bank for debit card transactions paid pursuant to the debit card program provided as part of the Services. The amount required for the reserve will range in percentage based on funding frequency and is projected based on the annual health FSA elections and dependent care FSA elections, or based on such other amount as may be agreed from time to time between the Service Manager and Plan Sponsor. Plan Sponsor agrees to replenish the reserve at the frequency elected in the Onboarding and Renewal Summary or as otherwise required by Gallagher. Plan Sponsor acknowledges that the amount required in the reserve will be calculated twice annually. Gallagher shall have the right to suspend claim processing and deactivate the debit card program if sufficient funds are not available for payment of claims or reimbursement of debit card transactions. In the event of deactivation, the reactivation fee of \$500.00 will apply and will be communicated to and payable by Plan Sponsor prior to

reactivation. Gallagher shall have no liability or responsibility for any claims, taxes, penalties, or other liabilities incurred by Plan Sponsor or any Plan participants as a result of such suspension or its inability to reimburse claims within timeframes required by applicable laws and regulations. The Plan Sponsor's obligation to maintain the reserve is subject to the Plan Sponsor's right to remove Gallagher and Gallagher's right to resign as provided in the MSA.

(c) No Trust Funds or Control of Assets. The parties acknowledge and agree that Gallagher shall be solely a designee of Plan Sponsor for payment of claims and expenses associated with the FSA Plan, and does not have any authority or control with respect to the management of the FSA Plan or disposition of plan assets, if any, and is not holding funds on behalf of or for the benefit of the Plan or any Plan participants.

(d) Cafeteria Plan Compliance. Plan Sponsor shall be solely responsible for the compliance of the Plan with the Plan Documents and all applicable laws and regulations, including but not limited to Internal Revenue Code Sections 125 and 105(h).

(e) Compliance with COBRA. Except for Services to administer the Special Limited COBRA Obligations on behalf of the Plan Sponsor for eligible FSA plan participants, as described in the Section 1 of this ASA, Plan Sponsor shall be solely responsible for ensuring compliance of any group health plan component of the Plan with health insurance continuation coverage obligations, including notification obligations, required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and other applicable law. If needed in order for Gallagher to provide the Services in compliance with the Plan Documents and applicable law, Plan Sponsor shall furnish to Gallagher, in a manner and frequency to be determined by the parties, information regarding the COBRA coverage elections of any Plan participants.

(f) Non-discrimination Testing. At the election of Plan Sponsor or Plan Administrator on an annual basis, Gallagher will perform non-discrimination testing for any HealthInvest Benefit Plan covered by this ASA to the extent required by the Internal Revenue Code. Plan Sponsor acknowledges and agrees that the accuracy of the results of such non-discrimination testing depends on the information supplied by Plan Sponsor or the Plan Administrator, including without limitation, census information and other information relating to compensation, benefits eligibility, direct employer contributions and elective pre-tax and after-tax employee contributions, bargaining agreements, etc., and Gallagher shall have the right to rely on the information provided by Plan Sponsor or Plan Administrator for purposes of conducting non-discrimination testing. Plan Sponsor acknowledges and agrees that the laws and proposed regulations relating to non-discrimination testing for cafeteria plans and their benefit components are complex and, in some cases, vague or subject to interpretation. Gallagher will use its best efforts to apply a reasonable or generally accepted interpretation of the non-discrimination testing rules in the manner most favorable to Plan Sponsor's Plan, and with respect to any non-discrimination testing performed by Gallagher on behalf of Plan Sponsor, Plan Sponsor shall indemnify and hold Gallagher harmless as provided in the MSA. Gallagher is under no obligation to perform non-discrimination testing on benefit plans not covered by the MSA or advise Plan Sponsor regarding specific corrective measures beyond providing the test results.

HealthInvest
PRICING APPENDIX

**for Services under any ASA elected by the Plan Sponsor
in its Onboarding and Renewal Summary**

Direct Compensation - Administration Fees and Expenses

The following schedule of administrative fees will apply. Administrative fees include expenses for routine operation, administration, and regulatory compliance for the Plan.

1. Monthly Per Participant Account Fee:

N/A

This amount will be deducted once per calendar month from Participant Accounts unless Employer elects below to pay this fee.

☐ Check here if Employer will pay. Monthly account fees will be invoiced to Employer monthly. Invoiced amounts shall be due and payable by Employer within 30 days.

2. Annualized Participant Account Fee:

N/A

This fee will be prorated and deducted from Participant Accounts on a daily basis at a rate of 1/365 of the listed annualized fee unless Employer elects below to pay this fee.

☐ Check here if Employer will pay. Annualized participant fees will be calculated and invoiced to Employer monthly. Invoiced amounts shall be due and payable by Employer within 30 days.

3. Employer Set-up Fee:

N/A

Employer will be invoiced at time of Plan adoption. Invoiced amounts shall be due and payable by Employer within 30 days.

4. Employer Annual Fee:

N/A

Employer will be invoiced beginning in year two and each year thereafter. Invoiced amounts shall be due and payable by Employer within 30 days.

5. Trust-level Expenses:

N/A

Employer will be invoiced beginning in year two and each year thereafter. Invoiced amounts shall be due and payable by Employer within 30 days.

Expenses related to the overall operation of the Plan Sponsor Trust on behalf of all participating employers, including, but not limited to, annual audit, completion and filing of IRS Form 990 return, legal fees, fiduciary liability insurance or fidelity bond(s) purchased as permitted by the Plan Documents, and other expenses incurred as part of the administration of the Trust, and split in accordance with the Plan Documents.

☐ Check here if Employer will pay.

☐ Check here if Trust-level Expenses should be split equally among Employer's Participant Accounts.

6. Termination/Transfer Fee:

N/A

Employer will be invoiced at the time of termination/transfer. Invoiced amounts shall be due and payable by Employer within 30 days.

7. Annual Patient-Centered Outcomes Research Institute (PCORI) Fee:

The PCORI Fee is an annual per-participant fee assessed by the federal government as required under federal healthcare reform regulations. The PCORI fee increases each year (through Plan Years beginning in 2029) based on increase in the projected per capita amount of national health expenditures.

Unless the Plan Sponsor elects otherwise, for non-ERISA Plans that are subject to this fee, the account of any Participant who is eligible to file claims will be charged a prorated portion of this annual fee once every three months during the Plan Year beginning in 2017 through the Plan Year beginning in 2029, or as otherwise mandated by federal law.

For ERISA-governed plans that are subject to this fee or if elected by the Plan Sponsor, the fee will be calculated by the HRA Service Manager, in consultation with the Plan Sponsor, and payable by the Plan Sponsor. The fee applies to claims eligible participants only and does not include their spouses and dependents. The amounts collected will be remitted to the federal government to fund patient-centered outcomes research.

☐ Check here if Employer will pay.

This Administrative Fee Schedule does not include investment fund operating expenses. Fund operating expenses vary by fund and are expressed in Plan literature as an annualized percentage of assets. Fund operating expenses are applied at the fund level.

Additional Fee Information:

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The above fees may be amended or restated from time to time in accordance with Sections 6 and 21 of the Master Services Agreement.

Indirect Compensation

Gallagher receives indirect compensation from the following sources, which cannot be quantified in advance and are dependent on many variables and subject to a range of compensation levels as described below:

Description	Fee
Benefit Card Interchange Share. This is indirect compensation paid to the recordkeeper by the card processor. <i>This is not indirect compensation to Gallagher.</i> This share is used to help offset the overall cost of administering the benefit card program. <i>Applicable for Benefits Cards used with ICHRA, HRA, FSA, and HSA.</i>	Benefit card interchange revenue allocated to the recordkeeper is based upon aggregate benefit card charges (or spend) on a monthly basis for all HealthInvest programs using a benefit card and does not exceed 1.5% of benefit card spend.
Carrier Compensation (for individual coverage placed through Alternative Health Solutions). HealthInvest makes Alternative Health Solutions available to Participants of certain Benefit Plans. Alternative Health Solutions is a free service to Participants that assists Participants in finding individual coverage that meets their needs. As compensation to Gallagher for the enrollment of individuals in individual market coverage (including Medicare Supplement or Medicare Advantage Plans), insurance carriers pay compensation on a per contract (or policy) basis that ranges in type and amount as described. <i>Applicable for all Benefit Plans where Alternative Health Solutions is offered for individual enrollment assistance.</i>	Carrier compensation varies as to the form of compensation (e.g., flat fee per policy or individual covered by the policy per month (which generally ranges from \$0 to \$30), percentage of premium (which is generally less than 5%), or flat fee per policy per year) and may have reduced compensation levels for subsequent policy years. For Medicare-related policies, the applicable agent or agency receives standard compensation rates as regulated by state and federal agencies and in some cases receives additional carrier overrides related to an overall volume of policies in place. Carrier compensation varies from carrier to carrier and state by state. In some cases, there is no compensation for enrollments with certain carriers.
FSA/HSA Store. HealthInvest makes available to all Benefit Plans the FSA or HSA store where participants can purchase qualified medical items. This is indirect compensation paid to Gallagher by the FSA Store Inc. for eligible products sold to Participants when using the HealthInvest Benefits Card or through a special link or within the portal or mobile applications.	The FSA/HSA Store revenue share is based upon a percentage of quarterly FSA/HSA Store sales revenue on products sold to participants, less any discounts, taxes and shipping. This is specifically when Participants shop using a special link from our portal or mobile application and/or use a coupon code, or by use of the HealthInvest Benefits Card directly with the store. The percentage is set on a sliding scale based on total sales in the quarter, ranging from 3% of sales revenue to a maximum of 6% of sales revenue across all HealthInvest Benefit Plans.

Additional Fees

Gallagher may provide additional services as agreed upon with the Plan Sponsor for which an additional fee will be agreed upon prior to performing the service.

HEALTHINVEST HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("**Agreement**") is entered into by and between Gallagher Benefit Services, Inc., as Service Manager ("**Business Associate**") on behalf of one or more group health plans of Renton Regional Fire Authority ("**Plan Sponsor**") (each such plan referred to herein singularly and collectively as "**Covered Entity**") and shall be effective as of the Effective Date of October 1, 2026 (the "Effective Date").

RECITALS:

WHEREAS, Covered Entity and Business Associate mutually desire to outline their individual responsibilities with respect to the use and/or disclosure of Protected Health Information ("**PHI**") as mandated by the Privacy Rule promulgated under the Administrative Simplifications subtitle of the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") including all pertinent regulations issued by the U.S. Department of Health and Human Services as outlined in 45 C.F.R. Parts 160, 162 and 164 ("**HIPAA Privacy Rules and/or Security Standards**"); and

WHEREAS, Covered Entity and Business Associate understand and agree that the HIPAA Privacy Rules and Security Standards requires the Covered Entity and Business Associate enter into a Business Associate Agreement which shall govern the use and/or disclosure of PHI and the security of PHI and ePHI.

NOW, THEREFORE, the parties hereto agree as follows:

1. **Definitions.** When used in this Agreement and capitalized, the following terms have the following meanings:
 - (a) "**Breach**" shall have the same meaning as the term "Breach" in 45 C.F.R. §164.402.
 - (b) "**Electronic Protected Health Information**" or "**ePHI**" shall mean Protected Health Information transmitted by electronic media or maintained in electronic media.
 - (c) "**Individual**" shall have the same meaning as the term "Individual" in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).
 - (d) "**Privacy Rule**" shall mean the Standards for Privacy of Individual Identifiable Health Information as set forth at 45 C.F.R. Parts 160 and 164 Subparts A and E.
 - (e) "**Protected Health Information**" or "**PHI**" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

- (f) **"Required by Law"** shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.103.
- (g) **"Secretary"** shall mean the Secretary of the Department of Health and Human Services or his or her designee.
- (h) **"Security Incident"** shall mean any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or systems operations in an electronic information system.
- (i) **"Security Rule"** shall mean the Standards for Security of PHI, including ePHI, as set forth at 45 C.F.R. Parts 160 and 164 Subparts A and C.
- (j) **"Unsecured Protected Health Information"** shall mean protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary.

Terms used but not defined in this Agreement shall have the same meaning as those terms in the HIPAA regulations.

2. Obligations and Activities of Business Associate Regarding PHI.

- (a) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as Required by Law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.
- (c) Business Associate agrees to ensure that any agents, including sub-contractors (excluding entities that are merely conduits), to whom it provides PHI agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- (d) Business Associate agrees to provide access, at the request of Covered Entity, and in a reasonable time and manner designated by Covered Entity, to PHI in a Designated Record Set that is not also in Covered Entity's possession, to Covered Entity in order for Covered Entity to meet the requirements under 45 C.F.R. § 164.524.
- (e) Business Associate agrees to make any amendment to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 in a reasonable time and manner designated by Covered Entity.
- (f) Business Associate agrees to make internal practices books and records relating to the use and disclosure of PHI available to the Secretary, in a reasonable time and

manner as designated by the Covered Entity or Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. Business Associate shall immediately notify Covered Entity upon receipt or notice of any request by the Secretary to conduct an investigation with respect to PHI received from the Covered Entity.

- (g) Business Associate agrees to document any disclosures of PHI that are not excepted under 45 C.F.R. § 164.528(a)(1) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- (h) Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with paragraph (g) above, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- (i) Business Associate agrees to use or disclose PHI pursuant to the request of Covered Entity; provided, however, that Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

3. Permitted Uses and Disclosures of PHI by Business Associate.

- (a) Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.
- (b) Business Associate may use PHI for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate.
- (c) Business Associate may disclose PHI for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate if:
 - (i) such disclosure is required by Law; or
 - (ii) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that such information will remain confidential and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person agrees to notify Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.
- (d) Business Associate shall limit the PHI to the extent practicable, to the limited data set or if needed by the Business Associate, to the minimum necessary to accomplish

the intended purpose of such use, disclosure or request subject to exceptions set forth in the Privacy Rule.

- (e) Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

4. Obligations of Covered Entity Regarding PHI.

- (a) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice.
- (b) Covered Entity shall provide Business Associate with any changes in, or revocation of, authorization by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.
- (c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, if such restrictions affect Business Associate's permitted or required uses and disclosures.
- (d) Covered Entity shall require all of its employees, agents and representatives to be appropriately informed of its legal obligations pursuant to this Agreement and the Privacy Rule and Security Standards required by HIPAA and will reasonably cooperate with Business Associate in the performance of the mutual obligations under this Agreement.

5. Security of Protected Health Information.

- (a) Business Associate has implemented policies and procedures to ensure that its receipt, maintenance, or transmission of all PHI, either electronic or otherwise, on behalf of Covered Entity complies with the applicable administrative, physical, and technical safeguards required protecting the confidentiality, availability and integrity of PHI as required by the HIPAA Privacy Rules and Security Standards.
- (b) Business Associate agrees that it will ensure that agents or subcontractors agree to implement the applicable administrative, physical, and technical safeguards required to protect the confidentiality, availability and integrity of PHI as required by HIPAA Privacy Rules and Security Standards.
- (c) Business Associate agrees to report to Covered Entity any Security Incident (as defined 45 C.F.R. Part 164.304) of which it becomes aware. Business Associate agrees to report the Security Incident to the Covered Entity as soon as reasonably practicable, but not later than 10 business days from the date the Business Associate becomes aware of the incident.

- (d) Business Associate agrees to establish procedures to mitigate, to the extent possible, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Agreement.
- (e) Business Associate agrees to immediately notify Covered Entity upon discovery of any Breach of Unsecured Protected Health Information (as defined in 45 C.F.R. §§ 164.402 and 164.410) and provide to Covered Entity, to the extent available to Business Associate, all information required to permit Covered Entity to comply with the requirements of 45 C.F.R. Part 164 Subpart D.
- (f) Covered Entity agrees and understands that the Covered Entity is independently responsible for the security of all PHI in its possession (electronic or otherwise), including all PHI that it receives from outside sources including the Business Associate.

6. **Term and Termination.**

- (a) ***Term.*** This Agreement shall be effective as of the Effective Date and shall remain in effect until the Business Associate relationship with the Covered Entity is terminated and all PHI is returned, destroyed or is otherwise protected as set forth in Section 6(d).
- (b) ***Termination for Cause by Covered Entity.*** Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall provide an opportunity for Business Associate to cure the breach. If Business Associate does not cure the breach within 30 days from the date that Covered Entity provides notice of such breach to Business Associate, Covered Entity shall have the right to immediately terminate this Agreement and the underlying services agreement between Covered Entity and Business Associate.
- (c) ***Termination by Business Associate.*** This Agreement may be terminated by Business Associate upon 30 days prior written notice to Covered Entity in the event that Business Associate, acting in good faith, believes that the requirements of any law, legislation, consent decree, judicial action, governmental regulation or agency opinion, enacted, issued, or otherwise effective after the date of this Agreement and applicable to PHI or to this Agreement, cannot be met by Business Associate in a commercially reasonable manner and without significant additional expense.
- (d) ***Effect of Termination.*** Upon termination of this Agreement for any reason, at the request of Covered Entity, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. Business Associate shall not retain any copies of the PHI unless return or destruction is deemed infeasible. If the return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that

make the return or destruction infeasible, for so long as Business Associate maintains such PHI. For purposes of illustration only and not to limit the set of circumstances that could potentially make return or destruction infeasible, it would be infeasible for Business Associate to return or destroy certain PHI that is part of work product that must be retained for document retention/archival purposes, as well as PHI that is stored as a result of backup e-mail systems that store e-mails for emergency backup purposes.

7. Amendment.

(a) The parties may agree to amend this Agreement from time to time in any other respect that they deem appropriate. Except as provided in sub-paragraph 7(b), this Agreement shall not be amended except by written instrument executed by the parties.

(b) If Business Associate submits to Covered Entity a proposed amendment to this Agreement that is required by applicable law, and after reasonable attempts to obtain execution of such amendment from the Covered Entity, Business Associate is unable to obtain execution by Covered Entity, then such amendment to this Agreement executed by Business Associate shall be effective to amend this Agreement but only to the extent the provisions of such amendment are required for Business Associate or Covered Entity to comply with applicable law.

8. Indemnification.

Business Associate shall indemnify and hold harmless Covered Entity from and against any and all costs, expenses, claims, demands, causes of action, damages, attorneys' fees and judgments that arise out of or that may be imposed upon, incurred by, or brought against Covered Entity to the extent directly resulting from a breach of this Agreement or any violation of the Privacy Rule or other applicable HIPAA regulations by Business Associate. The indemnification obligations provided for in this Section will commence on the effective date of this Agreement and will survive its termination.

Covered Entity shall indemnify and hold harmless Business Associate from and against any and all costs, expenses, claims, demands, causes of action, damages, attorneys' fees and judgments that arise out of or are imposed upon, incurred by, or brought against Business Associate to the extent directly resulting from a breach of this Agreement or any violation of the Privacy Rule or other applicable HIPAA regulations by Covered Entity. The indemnification obligations provided for in this Section will commence on the effective date of this Agreement and will survive its termination.

9. Severability.

The parties intend this Agreement to be enforced as written. However, (i) if any portion or provision of this Agreement is to any extent declared illegal or unenforceable by a duly authorized court having jurisdiction, then the remainder of this Agreement, or the application of such portion or provision in circumstances other than those as to which it is so declared illegal or unenforceable,

will not be affected thereby, and each portion and provision of this Agreement will be valid and enforceable to the fullest extent permitted by law; and (ii) if any provision, or part thereof, is held to be unenforceable because of the duration of such provision, the Covered Entity and the Business Associate agree that the court making such determination will have the power to modify such provision, and such modified provision will then be enforceable to the fullest extent permitted by law.

10. Notices.

All notices, requests, consents and other communications hereunder will be in writing, will be addressed to the receiving party's address set forth below or to such other address as a party may designate by notice hereunder, and will be either (i) delivered by hand, (ii) made facsimile transmission, (iii) sent by overnight courier, or (iv) sent by registered mail or certified mail, return receipt requested, postage prepaid.

If to the Covered Entity:

Renton Regional Fire Authority
18002 108th Ave SE
Renton, WA 98055

If to the Business Associate:

Gallagher Benefit Services, Inc.
221 N Wall St, Suite 201
Spokane, WA 99201

11. Regulatory References.

A reference in this Agreement to a section in the Privacy Rule means the referenced section or its successor, and for which compliance is required.

12. Headings and Captions.

The headings and captions of the various subdivisions of the Agreement are for convenience of reference only and will in no way modify or affect the meaning or construction of any of the terms or provisions hereof.

13. Entire Agreement.

This Agreement sets forth the entire understanding of the parties with respect to the subject matter set forth herein and supersedes all prior agreements, arrangements and communications, whether oral or written, pertaining to the subject matter hereof.

14. Binding Effect.

The provisions of this Agreement shall be binding upon and shall inure to the benefit of both Parties and their respective successors and assigns.

15. No Waiver of Rights, Powers and Remedies.

No failure or delay by a party hereto in exercising any right, power or remedy under this Agreement, and no course of dealing between the parties hereto, will operate as a waiver of any such right, power or remedy of the party. No single or partial exercise of any right, power or remedy under this Agreement by a party hereto, nor any abandonment or discontinuance of steps to enforce any such right, power or remedy, will preclude such party from any other or further exercise thereof or the exercise of any other right, power or remedy hereunder. The election of any remedy by a party hereto will not constitute a waiver of the right of such party to pursue other available remedies. No notice to or demand on a party not expressly required under this Agreement will entitle the party receiving such notice or demand to any other or further notice or demand in similar or other circumstances or constitute a waiver of the right of the party giving such notice or demand to any other or further action in any circumstances without such notice or demand. The terms and provisions of this Agreement may be waived, or consent for the departure therefrom granted, only by written document executed by the party entitled to the benefits of such terms or provisions. No such waiver or consent will be deemed to be or will constitute a waiver or consent with respect to any other terms or provisions of this Agreement, whether or not similar. Each such waiver or consent will be effective only in the specific instance and for the purpose for which it was given, and will not constitute a continuing waiver or consent.

16. Governing Law.

This Agreement will be governed by and construed in accordance with the laws of the State of domicile of the Plan Sponsor.

17. Interpretation.

It is the Parties' intent to comply strictly with all applicable laws, including without limitation, HIPAA, state statutes, or regulations (collectively, the "Regulatory Laws"), in connection with this Agreement. In the event there shall be a change in the Regulatory Laws, or in the reasoned interpretation of any of the Regulatory Laws or the adoption of new federal or state legislation, any of which are reasonably likely to materially and adversely affect the manner in which either Party may perform or be compensated under this Agreement or which shall make this Agreement unlawful, the Parties shall immediately enter into good faith negotiations regarding a new arrangement or basis for compensation pursuant to this Agreement that complies with the law, regulation or policy and that approximates as closely as possible the economic position of the Parties prior to the change. In addition, the Parties hereto have negotiated and prepared the terms of this Agreement in good faith with the intent that each and every one of the terms, covenants and conditions herein be binding upon and inure to the benefit of the respective Parties. To the extent

this Agreement is in violation of applicable law, then the Parties agree to negotiate in good faith to amend this Agreement, to the extent possible consistent with its purposes, to conform to law.

IN WITNESS WHEREOF, the parties have executed this Business Associate Agreement as of the Effective Date.

BUSINESS ASSOCIATE:

Gallagher Benefit Services, Inc.

By: _____

Name: David Ritchie

Title: National Practice Leader, HRA VEBA & Trusts

Date: _____

COVERED ENTITY:

Renton Regional Fire Authority

By: _____

Name: Steven C. Heitman

Title: Fire Chief

Date: September 14, 2026

RENTON REGIONAL FIRE AUTHORITY

RESOLUTION NO. 2023-02

AMENDMENT TO NWFFT-RENTON REGIONAL FIRE AUTHORITY'S BENEFIT PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

WHEREAS, NWFFT-Renton Regional Fire Authority's Benefit (FSA) Plan Document and Summary Plan Description have been amended and restated effective January 1, 2023 (original effective date of 07/01/2016); and

WHEREAS, language has been updated regarding the plan dollar amounts and rollover according to the IRS allowed amounts for 2023.

NOW, THEREFORE, BE IT HEREBY RESOLVED, that the form of amended and restated Welfare Benefit Plan, effective January 1, 2023, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are here by authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan; and

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan; and

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

ADOPTED by the Governing Board of Renton Regional Fire Authority, at an open public meeting of such Board on the 13th day of February 2023 the following Board Members being present and voting:


Valerie O'Halloran (Feb 16, 2023 11:22 PST)

Board Member


Kerry Abercrombie (Feb 16, 2023 18:11 PST)

Board Member


Ruth Perez (Feb 14, 2023 20:54 PST)

Board Member


Marcus Morrell (Feb 14, 2023 14:41 PST)

Board Member


James H. Allertson, Jr. (Feb 15, 2023 11:11 PST)

Board Member


Sean Cook (Feb 14, 2023 14:49 PST)

Board Member



NWFFT - Renton Regional Fire Authority

NWFFT - Renton Regional Fire Authority
18002 108th Ave SE,,
Renton, WA 98055

NWFFT - Renton Regional Fire Authority FSA Plan

Plan Document

Amended and Restated January 01, 2023

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NWFFT - Renton Regional Fire Authority

NWFFT - Renton Regional Fire Authority FSA Plan

INTRODUCTION

The company amends and restates this Plan as of January 01, 2023 with an original effective date of July 01, 2016. Its purpose is to provide benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to elect between cash compensation or certain nontaxable benefit options as they desire. The Plan shall be known as the NWFFT - Renton Regional Fire Authority FSA Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

I. ARTICLE - PLAN DEFINITIONS

01. **"Administrator"** means the Employer, unless another person or entity has been designated by the Employer pursuant to the Article titled: "Administration" to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including but not limited to the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.
02. **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in the Article titled: "Benefit Information".
03. **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under the Article titled: "Benefit Information". Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.
04. **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.
05. **"Compensation"** means the amounts received as compensation by the Participant from the Employer during a Plan Year.
06. **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

"Dependent" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his or her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

07. **"Effective Date"** means July 01, 2016.
08. **"Election Period"** means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to the Article titled: "Participant Elections".
09. **"Eligible Employee"** means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

[Back to Top](#) An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll

records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

10. **"Employee"** means any person who is currently or hereafter employed by the Employer.

The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

11. **"Employer"** means NWFFT - Renton Regional Fire Authority and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, or Adopting Employer.
12. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
13. **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit, or any self-funded arrangement providing any Benefit offered for health and welfare coverage to Eligible Employees of the Employer.
14. **"Insurance Premium Payment Plan"** means the plan of benefits contained in the "Benefit Options" section of this Plan, which provides for the payment of Premium Expenses.
15. **"Insurer"** means any insurance company that underwrites a Benefit or any self-funded arrangement under this Plan.
16. **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.
17. **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to the Section titled: "Application to Participate" and has not for any reason become ineligible to participate further in the Plan.
18. **"Plan"** means the flexible benefits plan described in this instrument, including all amendments thereto.
19. **"Plan Year"** means the 12-month period beginning January 01 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.
20. **"Premium Expenses"** or **"Premiums"** means the Participant's cost for the Benefits described in the Section titled: "Benefit Options".
21. **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.
22. **"Qualified Reservist"** means a Participant of the plan who is a member of a reserve component such as: the Army National Guard; the Air National Guard; the Army Reserve; the Navy Reserve; the Marine Corps Reserve; the Air Force Reserve; the Coast Guard Reserve; the Reserve Corps of the Public Health Service; or as defined 37 U.S.C Section 101.
23. **"Qualified Reservist Distribution"** means a distribution to a Participant which includes a portion or the balance in the Participant's Health Flexible Spending Account as described in the Article titled: "Qualified Reservist Distribution".
24. **"Run-out Period"** means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.
25. **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to the Section titled: "Salary Redirection". These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under the Article titled: "Participant Elections".
26. **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his or her Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

27. **"Spouse"** means "spouse" as defined in an Insurance Contract, then, for purposes of coverage under that Insurance Contract only, "spouse" shall have the meaning stated in the Insurance Contract. In all other cases, "spouse" shall have the meaning stated under applicable federal or state law.

II. ARTICLE - PARTICIPATION

01. **ELIGIBILITY**

An individual is eligible to participate in this Plan if the individual:

- a. is an Eligible Employee as defined in the Article titled: "Definitions"
- b. is working an average of 0 hours or more per week; and
- c. is eligible for the group medical plan

02. **EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the first day of the next month following your date of hire.

03. **APPLICATION TO PARTICIPATE**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his or her Benefit elections pursuant to the Section titled: "Change in Status".

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance, unless the Employee elects, during the Election Period, not to participate in the Plan.

04. **TERMINATION OF PARTICIPATION**

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- a. **Termination of employment.** The termination of Participant's employment, subject to the provisions of the Section titled: "Termination of Employment"
- b. **Death.** The Participant's death, subject to the provisions of the Section titled: "Death" or
- c. **Termination of the plan.** The termination of this Plan, subject to the provisions of the Section titled: "Termination".

05. **TERMINATION OF EMPLOYMENT**

If a Participant's employment with the Employer is terminated for any reason other than death, his or her participation in the Benefit Options provided under the Section titled: "Benefit Options" shall be governed in accordance with the following:

- a. **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid.
- b. **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment-related Dependent Care Expense reimbursements for expenses within 90 days after the end of the Plan Year, limited by the balance in the Participant's Dependent Care Flexible Spending Account as of the date of termination.
- c. **Health FSA, COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which contributions to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section titled: "Continuation of Coverage" of the Plan.
- d. **Limited Purpose FSA, COBRA applicability** With regard to the Limited Purpose Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year for which payments to the Limited Purpose Flexible Spending

Account have already been made. Thereafter, the benefits under this Plan, shall be applied and administered consistent with such further rights that a Participant and his or her Dependents may be entitled to pursuant to Code Section 4980B and the Section of this Plan Document titled: "Continuation of Coverage".

06. REINSTATEMENT OF A FORMER PARTICIPANT

An Employee whose participation terminates and returns to an eligible status less than thirty days later may re-enroll within thirty days of returning to an eligible status with a commencement date of the first of the month following the adjusted eligibility date. An Employee who re-enrolls in a Health Flexible Spending Account or Dependent Care Account after such time must re-enter the Plan and reinstate their original elections for that Plan Year with adjustments to the annual election amount as the Administrator deems necessary to prorate the annual election amount over the remainder of the Plan Year. Expenses incurred by the employee during the time that the employee was not a Participant will not be covered expenses unless COBRA was elected pursuant to the Article titled: "Continuation of Coverage (COBRA)".

Any Employee who terminates employment and is rehired into an eligible status after thirty days from the date of termination will be treated as a new enrollee under the Plan. If such Employee returns within the same Plan Year, prior contributions made to the Health Flexible Spending Account and/or the Dependent Care Account will be taken into consideration so as not to exceed Plan or IRS maximums.

07. DEATH

If a Participant dies, his or her participation in the Plan shall immediately cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to a particular specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

III. ARTICLE - CONTRIBUTIONS TO THE PLAN

01. SALARY REDIRECTION

Subject to the provisions of the section titled "Employer Contributions," benefits under the Plan shall be financed by Salary Redirections sufficient to support the benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his or her pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participant's elections made under the Section titled: "Initial Elections".

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to the Section titled: "Initial Elections") and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under the Article titled: "Participant Elections" and are consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

02. APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

03. PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

04. EMPLOYER CONTRIBUTIONS

The Employer may provide non-elective contributions in the form of Employer Funding into the Health Flexible Spending Account, Limited Purpose Flexible Spending Account, and Dependent Care Spending Account to the extent as described in the Section Titled: "Limitation on Allocations". Such contributions may be prorated for Participants who begin participating in the middle of the Plan Year. Contributions or matching contributions made to the Health Flexible Spending Account, Limited Purpose Flexible Spending Account, and Dependent Care Spending Account generally do not count toward the annual contribution limit as described in the Section Titled: "Limitation on Allocations".

IV. ARTICLE - BENEFITS

01. **BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- Health Flexible Spending Account
- Limited Purpose Flexible Spending Account
- Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his or her Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

- Group Medical Plan
- Group Dental Plan
- Group Vision Plan

02. **HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

03. **LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Limited Purpose Flexible Spending Account option, in which case the Article titled: "Health Flexible Spending Account" shall apply.

04. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case the Article titled: "Dependent Care Flexible Spending Account" shall apply.

05. **HEALTH INSURANCE BENEFIT**

- a. **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.
- b. **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

06. **DENTAL INSURANCE BENEFIT**

- a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.
- b. **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.
- c. **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

07. **VISION INSURANCE BENEFIT**

- a. **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.
- b. **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which contracts will provide uniform benefits for all Participants electing this Benefit.

c. **Contract incorporated by reference.** The rights and conditions with respect to the

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benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

08. **NONDISCRIMINATION REQUIREMENTS**

- a. **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.
- b. **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.
- c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination is prohibited by Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his or her non-taxable Benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his or her non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

09. **NON-TAX DEPENDENT COVERAGE**

- a. If (i) Employee Salary Redirections are made to fund Benefits under the Plan, and (ii) the Employer allows a Participant to elect to cover a Non-Tax Dependent through the Participant's coverage under group Medical, Dental or Vision benefit(s), a Participant who elects to participate in the Salary Redirection program may pay on a pre-tax basis through salary reduction contributions the Participant's portion of the premium cost of coverage under the Employer's Medical, Dental or Vision Benefits, provided that the full fair market value of such Medical, Dental or Vision coverage for any such Non-Tax Dependent shall be includible in the Participant's gross income as a taxable benefit in accordance with applicable federal income tax rules. For purposes of this Plan, the Participant electing coverage for Non-Tax Dependent(s) shall be treated as receiving, at the time that coverage is received, cash compensation equal to the full fair market value of such coverage and then as having purchased the coverage with after-tax employee contributions.
- b. Notwithstanding the foregoing, no medical care or dependent care expenses incurred by or with respect to a Non-Tax Dependent of a Participant shall be eligible for reimbursement as eligible expenses under the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

V. ARTICLE - PARTICIPANT ELECTIONS

01. INITIAL ELECTIONS

An Employee who meets the eligibility requirements of the Section titled: "Eligibility" on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his or her effective date of participation pursuant to the Section titled: "Effective Date of Participation".

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employer's insured benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

02. SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form or electronically, as provided by the Administrator, which spending account Benefit options he wishes to participate in. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which immediately follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

- a. A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;
- b. A Participant may terminate his or her participation in the Plan by notifying the Administrator in writing or by electronic notification, as determined by the Employer, during the Election Period that he does not want to participate in the Plan for the next Plan Year;
- c. An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in the Section titled: "Change of Status".

03. FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits, subject to the provisions of the Section titled: "Change in Status" below.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election pursuant to the Section titled: "Subsequent Annual Elections" by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

04. CHANGE IN STATUS

- a. **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with any of the provisions of this Plan, then such rules and regulations shall control. See below in this Section for other situations in which changes in Benefit elections are permitted.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains eligibility for coverage under any other plan, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan is consistent with that change in status only if coverage for that individual becomes applicable or is increased under said other plan. Also, if the Participant, Spouse or Dependent loses eligibility for coverage under any other plan, then a Participant's election under the Plan to start or increase coverage for that individual under the Plan is consistent with that change in

status only if coverage for that individual ceases or is decreased under said other plan.

Regardless of the consistency requirement, if the individual, or the individual's Spouse or Dependent, becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
2. Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
3. Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
5. Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and IRS Notice 2010-38, shall qualify as a change in status.

- b. **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.
- c. **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) (collectively, an "order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) that requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):
 1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
 2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan, and such coverage is actually provided.
- d. **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or

Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

- e. **Cost increase or decrease.** Notwithstanding subsection (a), if the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

- f. **Loss of coverage.** Notwithstanding subsection (a), if the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- g. **Addition of a new benefit.** Notwithstanding subsection (a), if, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.
- h. **Loss of coverage under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
- i. **Change of coverage due to change under certain other plans.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse, former Spouse's employer or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse, former Spouse's employer or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse, former Spouse's employer or Dependent's employer.
- j. **Change in dependent care provider.** Notwithstanding subsection (a), a Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in a dependent care provider. The availability of dependent care services from a new dependent care provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).
- k. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant changes from full-time employment (i.e., an average of 30 hours of service per week) to part-time employment (i.e., an average of less than 30 hours of service per week), even if the Participant continues to be eligible for coverage under the group health plan, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in another plan that provides minimum essential coverage and is effective no later than the first day of the second month after the month during which the revocation is effective.
- l. Notwithstanding subsection (a), a Participant may prospectively revoke his or her election of group health plan coverage if (i) the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace, or seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period, and (ii) the Participant, and any related individuals whose coverage is also to be revoked, intend to enroll in a Qualified Health Plan through a Marketplace that is effective no later than the day immediately following the effective date of the revocation.

- m. **Health Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.
- n. **Limited Purpose Flexible Spending Account cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Limited Purpose Flexible Spending Account as a result of a cost or coverage change under any health insurance contract.

VI. ARTICLE - HEALTH FLEXIBLE SPENDING ACCOUNT

01. ESTABLISHMENT OF BENEFIT

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of allowable Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

02. DEFINITIONS

For the purposes of this Article and the Plan, the terms below have the following meanings:

- a. **"Health Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by the Participant, his or her Spouse and his or her Dependents may be reimbursed.
- b. **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:
 1. one of the 5 highest paid officers;
 2. a shareholder who owns (or is considered to own, applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
 3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- c. **"Limited Purpose Flexible Spending Account"** means the account established for a Participant pursuant to this Plan to which part of his or her Plan Benefit Dollars may be allocated and from which all allowable Dental, Vision, and Preventative Care Expenses incurred by a Participant, his or her Spouse or his or her Dependents may be reimbursed. This account is for Participants that are making contributions to a Health Savings Account (HSA) within the same plan year.
- d. **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his or her tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his or her Spouse or Dependent.

- e. A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).
- f. The definitions of the Article titled: "Plan Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

03. FORFEITURES

A Participant in the Health Care Flexible Spending Account may roll over up to \$570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

A Participant in the Limited Purpose Flexible Spending Account may roll over up to \$570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue

Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

04. **LIMITATION ON ALLOCATIONS**

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Health Flexible Spending Account by a Participant in any Plan Year is \$3,050.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary redirections that may be allocated to the Limited Purpose Flexible Spending Account by a Participant in any Plan Year is \$3,050.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code.

Carryover: A Participant in the Health Care Flexible Spending Account may roll over up to \$570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

Carryover: A Participant in the Limited Purpose Flexible Spending Account may roll over up to \$570.00 of unused funds at the end of one Plan Year to the next Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. These funds can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirections otherwise permitted for said next Plan Year. Unused amounts are those remaining after all eligible expenses for the Plan Year have been reimbursed. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts in excess of maximum limit will be forfeited.

05. **NONDISCRIMINATION REQUIREMENTS**

- a. **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.
- b. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section and/or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

06. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Plan are eligible to receive Benefits under this Health Flexible Spending Account. Enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

07. **HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS**

- a. **Expenses must be incurred during Plan Year.** All eligible Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed, subject to the Section titled: "Termination of Employment", even though the

submission of such a claim occurs after his or her participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

- b. **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his or her Spouse or Dependents.
- c. **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time after incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.
- d. **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after the date of termination.

08. **DEBIT AND CREDIT CARDS**

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

- a. **Card only for medical expenses.** Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
- b. **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.
- c. **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Section titled: "Limitation on Allocations".
- d. **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
- e. **Card use.** The cards shall only be used for Medical Expense purchases as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, including, but not limited to, the following:
 - 1. Co-payments for doctor and other medical care;
 - 2. Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;
 - 3. Purchase of medical items such as eyeglasses, syringes, crutches, etc.
- f. **Substantiation.** Such purchases by the cards shall be subject to confirmation by the Administrator, usually by requiring the Participant to submit a receipt from a service provider

describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Administrator.

- g. **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
1. Repayment of the improper amount by the Participant;
 2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;
 3. Claims substitution or offset of future claims until the amount is repaid; and
 4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

VII. ARTICLE - DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

01. **ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

02. **DEFINITIONS**

For the purposes of this Article and the Plan, the terms below shall have the following meaning:

- a. **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his or her Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.
- b. **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.
- c. **"Employment-Related Dependent Care Expenses"** means the amounts paid for those expenses of a Participant that, if paid by the Participant, would be considered employment related expenses under Code Section 21(b)(2). Generally, they include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period during which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:
 1. If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment Related Dependent Care Expenses only if incurred for a Qualifying Dependent (as defined in the "Definitions" Section of the Article titled: "Dependent Care Flexible Spending Account") who regularly spends at least eight (8) hours per day in the Participant's household;
 2. If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and
 3. Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid to or incurred by a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.
- d. **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,
 1. a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;
 2. a Dependent or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or
 3. a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).
- e. The definitions of the Article titled: "Definitions" are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

03. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

04. **INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the amount of Cafeteria Plan Benefit Dollars that he has elected to apply toward his or her Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

05. **DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of the Participant pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof.

06. **ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in the Section titled: "Limitation on Payments" below, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

07. **ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under the Section titled: "Definitions" during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

08. **FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to the Section titled: "Dependent Care Flexible Spending Account Claims" hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

09. **LIMITATION ON PAYMENTS**

- a. **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any tax year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000.00 (or cannot exceed \$5,000 as provided under Code Section 129 or \$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

10. **NONDISCRIMINATION REQUIREMENTS**

- a. **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination is prohibited under Code Section 129(d).
- b. **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of (i) the stock of, or (ii) the capital or profits interest in, the Employer.
- c. **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination is prohibited by Code Section 129, it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

11. **COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

12. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all qualified Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- a. The Dependent or Dependents for whom the services were performed;
- b. The nature of the services performed for the Dependent, the cost of which the Participant wishes reimbursement;
- c. The relationship, if any, of the person performing the services to the Participant;
- d. If the services are being performed by a child of the Participant, the age of the child;
- e. A statement as to where the services were performed;
- f. If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;
- g. If the services were being performed in a day care center, a statement:
 1. that the day care center complies with all applicable laws and regulations of the state of residence,
 2. that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and
 3. of the amount of fee paid to the provider.
- h. If the Participant is married, a statement containing the following:
 1. the Spouse's salary or wages, if he or she is employed, or
 2. if the Participant's Spouse is not employed, that
 - i. he or she is incapacitated, or
 - ii. he or she is a full-time student attending an educational institution, and the months of the year during which he or she attends such institution.
- i. **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator.

VIII. ARTICLE - ERISA PROVISIONS

01. CLAIM FOR BENEFITS

- a. **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.
- b. **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 90 days after the date of termination. Once a claim is submitted, the following timetable for claims and the rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
6. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided with the denial free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a decision on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

- c. **Forfeitures.** Any balance remaining in the Participant's Dependent Care Flexible Spending Account or Health Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to the Section titled: "Forfeitures", whichever is applicable. Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

02. APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

03. NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

04. GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

- a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- c. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

05. NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so alienated or subjected shall not be recognized, except to such extent as may be required by law.

IX. ARTICLE - ADMINISTRATION

01. PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person or persons, including, but not limited to, one or more Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. An Administrator may resign by delivering a written resignation to the Employer or may be removed by the Employer by delivery of written notice of removal, to take effect at a date specified therein, or upon delivery if no date is specified. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

- a. To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- b. To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- c. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;
- d. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;
- e. To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
- f. To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
- g. To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such should be paid. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
- h. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and
- i. To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

02. EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to their interest under the Plan.

03. PAYMENT OF EXPENSES

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Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

04. **INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer or other benefit program that is self-insured whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

05. **INDEMNIFICATION OF ADMINISTRATOR**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

X. ARTICLE - AMENDMENT OR TERMINATION OF PLAN

01. AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state and local laws, statutes and regulations.

02. TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such accounts shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

XI. ARTICLE - MISCELLANEOUS

01. PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

02. GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

03. WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

04. EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

05. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment 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 or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

06. ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by the Employer.

07. EMPLOYER'S PROTECTIVE CLAUSES

- a. **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.
- b. **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

08. NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

09. INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant

as regular cash compensation, plus the Participant's share of any Social Security tax and Medicare tax that would have been paid on such compensation, less any such additional income tax, Social Security tax, and Medicare tax actually paid by the Participant.

10. FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11. GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event does the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of Washington.

12. SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

13. CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

14. CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

15. FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

16. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

17. UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

18. QUALIFIED RESERVIST DISTRIBUTIONS

Notwithstanding any provision of this Plan to the contrary, a Participant may elect to receive a distribution of certain funds from his or her Health Flexible Spending Account or Limited Purpose Flexible Spending Account if the following criteria is met:

1. The Participant is a Qualified Reservist as defined in the Section titled: "Definitions".
2. The Participant is ordered or called to active duty for a period in excess of 180 days or more, or for an indefinite period. If the period is less than 180 days, a Qualified Reservist Distribution is not allowed unless there are subsequent orders or calls for duty that increase the total period of active duty to 180 days or more.
3. The Participant has provided the Plan Administrator with a copy of the order or call to active duty and;
4. The request for distribution is made during the period beginning with the order or call to duty and ending on the last day of the Plan Year (or Grace Period if applicable, as defined in the Article titled: "Definitions") in which the order or call to duty occurred. The Participant delivers a written election to the Plan Administrator in a form designated or requested by the

Plan Administrator.

The amount of the QRD shall be the amount contributed to the account as of the date of the QRD request minus reimbursements received as of the date of the QRD request.

19. **COMPLIANCE WITH HIPAA PRIVACY STANDARDS**

- a. **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.
- b. **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- c. **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information will not be used or disclosed for underwriting purposes.
- d. **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.
 1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:
 - i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
 - iii. mitigation of any harm caused by the breach, to the extent practicable; and
 - iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- e. **Certification.** The Employer must and hereby does provide certification to the Plan that it agrees to adopt all required provisions as mandated under HIPAA for all non-exempt group health plans, including the following:
 1. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
 2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
7. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

20. **COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- a. **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- b. **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- c. **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "Compliance with HIPAA Privacy Standards".

21. **MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

22. **GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

23. **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

24. **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

Execution Agreement

IN WITNESS WHEREOF, NWFFT - Renton Regional Fire Authority has caused its authorized officer to execute this amended and restated Plan document as of February 13, 2023, the same to be effective **January 01, 2023**, unless otherwise indicated herein.

NWFFT - Renton Regional Fire Authority

By:

Samantha Babich

Name:

Samantha Babich

Title:

Chief Administration Officer

CERTIFICATE OF RESOLUTION

The undersigned authorized representative of **NWFFT - Renton Regional Fire Authority** (the Employer) hereby certifies that the following resolutions were duly adopted by the governing body of the Employer on February 13, 2023, and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of amended and restated Welfare Benefit Plan, effective January 01, 2023, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper agents of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

RESOLVED, that the Administrator shall be instructed to take such actions that the Administrator deems necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures for the provision of benefits under the Plan.

RESOLVED, that the proper agents of the Employer shall act as soon as possible to notify the employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

The undersigned further certifies that attached hereto as Exhibits, are true copies of NWFFT - Renton Regional Fire Authority's Benefit Plan Document and Summary Plan Description approved and adopted at this meeting.

NWFFT - Renton Regional Fire Authority

By: Samantha Babich

Name: Samantha Babich

Title: Chief Administration Officer



NWFFT - Renton Regional Fire Authority

NWFFT - Renton Regional Fire Authority
18002 108th Ave SE,,
Renton, WA 98055

NWFFT - Renton Regional Fire Authority FSA Plan

Summary Plan Description

Amended and Restated January 01, 2023

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NWFFT - Renton Regional Fire Authority

NWFFT - Renton Regional Fire Authority FSA Plan

INTRODUCTION

The Company's Flexible Benefit Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the Company. If the Plan is ever amended or changed, the Company will notify you.

This SPD was designed to provide you with information regarding the Company Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

I. ARTICLE - ELIGIBILITY

01. **How can I participate in the Plan?**

Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 0 or more hours per week and meet the eligibility requirements.

After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

02. **What are the eligibility requirements for our Plan?**

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and the other eligibility requirements established by your employer as defined in section 1.

03. **When can I enter the plan?**

An Eligible Employee shall become a Participant effective as of the first day of the next month following your date of hire.

04. **How do I enroll in the Plan?**

Before you can join the Plan, you must complete an enrollment form. The enrollment form will allow you to select which benefits you want to participate in under the Plan. This form will also authorize the Company to redirect some of your earnings in order to pay for the benefits you select.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan. These benefits are listed in the Article titled: "Benefits".

II. ARTICLE - OPERATION

01. **How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

III. ARTICLE - CONTRIBUTIONS; ELECTIONS

01. **How much of my pay may the Employer redirect?**

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

02. **What happens to contributions made to the Plan?**

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. In addition, you should also note that any previous benefit payments made from any Account under the Plan that are unclaimed (e.g., uncashed benefit checks) at the end of the Plan Year following the period of coverage in which the qualifying expense was incurred will be forfeited to the Employer.

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

03. **When must I decide which accounts I want to use?**

You are required by Federal regulations to decide during the enrollment or election period (defined below) prior to the Plan Year start. You must decide which accounts you want and how much you want to contribute to each account.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance, unless you elect during the election period (defined below) not to participate in the Plan.

04. **When is the election period for our Plan?**

You will make your initial election on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Company and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Company will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

05. **May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections.

You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the

law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse, former spouse or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

In addition, there are laws that give you rights to change group health coverage for you, your spouse, and/or your dependents (i) if you go from working 30 or more hours a week to working less than 30 hours a week and you intend to enroll in certain other health plans, or (ii) if you are eligible to enroll in and intend to enroll in certain Marketplace Qualified Health Plans. If you change coverage due to rights under these laws, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the administrator.

06. May I make new elections in future Plan Years?

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, the Company will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV. ARTICLE - BENEFITS

01. What benefits are offered under the Plan?

You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

02. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by our insured medical plan, and to save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account for the Plan Year is \$3,050.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. In addition, you may carry over any amount left in your account up to \$570.00. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. This amount can be used the following Plan year to pay for eligible expenses.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. The Company will also provide you with a debit card to use to pay for qualified medical expenses. The Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A "child" is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status for purposes of coverage changes.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

03. Limited Purpose Flexible Spending Account

The Limited Purpose Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Limited Purpose Flexible Spending Account allows you to be reimbursed by the Employer for out-of-pocket Dental, Vision, and Preventative Care Expenses incurred by you and your dependents.

Drug costs may be reimbursed if they are considered for dental, vision or preventive care.

The most that you can contribute to your Limited Purpose Flexible Spending Account each Plan Year is \$3,050.00. The maximum limit may increase from year-to-year pursuant to Section 125(i)(2) of the Internal Revenue Code. In addition, you may carry over any amount left in your account at the end of the Plan Year, up to \$570.00. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. This amount can be used the following Plan year to pay for eligible expenses.

04. Dependent Care Flexible Spending Account

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The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is \$5,000.00.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000.00 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed annual earned income (a spouse who is a full time student or incapable of caring for himself/herself has a deemed monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

05. **Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various group insurance programs the Company offers you. These premium expenses include:

- Health care premiums under our insured group medical plan
- Dental insurance premiums
- Vision insurance premiums

Under this Plan, the Company will allocate the pre-tax premium withholding to the accounts established under the Plan pursuant to the Participants' elections. Certain limits on the amount of coverage that can be paid through pre-tax premiums may apply.

The Company may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. The Company will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

V. ARTICLE - BENEFIT PAYMENTS

01. **When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Health Flexible Spending Account or Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

02. **What happens if I don't spend all Plan contributions during the Plan Year?**

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the Employer. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited.

At the end of the Plan Year, and after all eligible reimbursements have been made, any unused funds up to \$570.00 in your Health Flexible Spending Account will roll over into the new Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. Any unused funds left in the account in excess of maximum limit will be forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

At the end of the Plan Year, and after all eligible reimbursements have been made, any unused funds up to \$570.00 in your Limited Purpose Flexible Spending Account will roll over into the new Plan Year. The maximum limit may increase from year-to-year as provided under IRS Notice 2020-33 and Section 125(i) of the Internal Revenue Code. Any unused funds left in the account in excess of maximum limit will be forfeited. For the Limited Purpose Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

03. **Family and Medical Leave Act (FMLA)**

If you take a leave under the Family and Medical Leave Act, you may continue, revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage for these benefits terminates, due to your revocation of the benefit to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - for example, from \$100 per month to \$150 per month, etc. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

04. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage through your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected, ask your Administrator for further details.

05. **QUALIFIED RESERVIST DISTRIBUTIONS**

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Notwithstanding any provision of this Plan to the contrary, a Participant may elect to receive a distribution of certain funds from his or her Health Flexible Spending Account or Limited Purpose Flexible Spending Account if the following criteria is met:

1. The Participant is a Qualified Reservist as defined in the Section titled: "Definitions".
2. The Participant is ordered or called to active duty for a period in excess of 180 days or more, or for an indefinite period. If the period is less than 180 days, a Qualified Reservist Distribution is not allowed unless there are subsequent orders or calls for duty that increase the total period of active duty to 180 days or more.
3. The Participant has provided the Plan Administrator with a copy of the order or call to active duty and;
4. The request for distribution is made during the period beginning with the order or call to duty and ending on the last day of the Plan Year (or Grace Period if applicable. For the years 2020 and 2021 only, the Grace Period will also include any and all claims incurred for any applicable Plan Year during that taxable year, plus the twelve month extension period.) in which the order or call to duty occurred. The Participant delivers a written election to the Plan Administrator in a form designated or requested by the Plan Administrator.

The amount of the QRD shall be the amount contributed to the account as of the date of the QRD request minus reimbursements received as of the date of the QRD request.

06. What happens if my employment terminates?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- a. You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- b. You will still be able to request reimbursement for qualifying dependent care expenses up to 90 days after the end of the Plan Year from the balance remaining in your Dependent Care Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.
- c. For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 90 days after the date of termination, claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."
- d. For the Limited Purpose Flexible Spending Account coverage on termination of employment, please see the Section entitled "Continuation Coverage Rights Under COBRA." Upon termination of employment, your participation in the Limited Purpose Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit, within 90 days after the date of termination, claims for eligible dental or vision expenses that were incurred before the end of the period for which payments to the Limited Purpose Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

07. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the Company contributions to Social Security on your behalf.

VI. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

01. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VII. ARTICLE - PLAN ACCOUNTING

01. **Periodic Statements**

Periodically during the Plan Year, the Administrator will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

01. **General Plan Information**

NWFFT - Renton Regional Fire Authority FSA Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The company amends and restates this Plan as of January 01, 2023 with an original effective date of July 01, 2016.

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

02. **Employer Information**

Your Employer's name, address, and tax identification number are:

NWFFT - Renton Regional Fire Authority
Samantha Babich
18002 108th Ave SE,,
Renton, WA 98055
425-276-9505
SBabich@rentonrfa.org
FEIN: 81-2447873

03. **Plan Administrator Information**

The name and address of your Plan's Administrator are:

NWFFT - Renton Regional Fire Authority
18002 108th Ave SE,,
Renton, WA 98055
425-276-9505
SBabich@rentonrfa.org

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan. The Plan's Agent of Service is:

NWFFT - Renton Regional Fire Authority
18002 108th Ave SE,,
Renton, WA 98055
425-276-9505
SBabich@rentonrfa.org

05. **Type of Administration**

The type of Administration is Employer Administration.

06. **Claims Submission**

Claims for expenses should be submitted to:

BPAS
820 Gessner Rd. Ste 1250
Houston, TX 77024
425-430-7025

IX. ARTICLE - ADDITIONAL PLAN INFORMATION

01. Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- a. examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (also available at the Public Disclosure Room of the Employee Benefits Security Administration);
- b. obtain copies of all documents that govern the operations of the Plan, and other Plan information, upon written request to the Administrator. The Administrator may charge a reasonable fee for copies;
- c. continue health coverage for yourself, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage; and
- d. review this summary plan description and the documents governing COBRA continuation rights under the Plan.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and the other Plan Participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

02. Claims Process

It is recommended that you submit all reimbursement claims during the Plan Year. For information on how claims will be processed at the end of the Plan Year, please refer to the Article titled: "Benefit Payments".

Claims for insured benefits will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If

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a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit to the Administrator a written request for reconsideration of the denial.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- a. The specific reason or reasons for the denial;
- b. Reference to the specific Plan provisions on which the denial was based;
- c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- d. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- e. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- f. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- a. was relied upon in making the claim determination;
- b. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

- d. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

03. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") beyond the time when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

01. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

02. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

03. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provides that the Plan participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- a. The death of a covered Employee.

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- b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- c. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- d. A covered Employee's enrollment in any part of the Medicare program.
- e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

04. What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should be aware that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

05. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

06. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

07. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- a. the end of employment or reduction of hours of employment,
- b. death of the employee,
- c. commencement of a proceeding in bankruptcy with respect to the Employer, or
- d. entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES: Any notice that you provide must be *in writing*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

NWFFT - Renton Regional Fire Authority

18002 108th Ave SE,,
Renton, WA 98055

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

08. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

09. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- a. The last day of the applicable maximum coverage period.
- b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- c. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- e. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- f. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 1. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

11. **What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- b. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- c. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- d. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

12. **Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of

the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

13. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

14. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

16. What is Timely Payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

17. Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

18. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

19. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money

than you have taken out in claims. For example, if you elected to contribute an annual amount of \$750 and, at the time you terminate employment, you have contributed \$400 but only claimed \$200, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$750. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Attachment A

****HIPAA NOTICE OF PRIVACY PRACTICES****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose

This notice is intended to inform you of the privacy practices followed by your employer's Healthcare Flexible Spending Account Plan. It also explains the Federal privacy rights afforded to you and the members of your family as Plan Participants covered under a group health plan.

As a Plan sponsor your employer often needs access to health information in order to perform Plan Administrator functions. We want to assure the Plan Participants covered under our group health plan that we comply with Federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices outlined below.

Uses and Disclosures of Health Information

Healthcare Operations. We use and disclose health information about you in order to perform Plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand utilization and to make plan design changes that are intended to control health care costs.

Payment. We may also use or disclose identifiable health information about you without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a healthcare provider that provided treatment to you will provide us with your health information. We use that information to determine whether those services are eligible for payment under our group health plan.

Treatment. Although the law allows use and disclosure of your health information for purposes of treatment, as a Plan sponsor we generally do not need to disclose your information for treatment purposes. Your physician or healthcare provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and healthcare operations.

As permitted or required by law. We may also use or disclose your health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share health information during a corporate restructuring such as an merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your identifiable health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to cease any future uses or disclosures.

Right to Inspect and Copy. In most cases, you have a right to inspect and copy the health information we maintain about you. If you request copies, we will charge you \$0.05 (5 cents) for each page. Your request to inspect or review your health information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures. You have a right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, or pursuant to your written authorization.

Right to Amend. If you believe that information within our records is incorrect or missing, you have a right to request that we correct the incorrect or missing information.

Right to Request Restrictions. You may request in writing that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have a right to receive confidential communications containing your health information. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Legal Information

The Company is required by law to protect the privacy of your information, provide this notice about information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our current notice at any time. For more information about our

privacy practices, contact the person listed below:

NWFFT - Renton Regional Fire Authority
Samantha Babich
18002 108th Ave SE,,
Renton, WA 98055
425-276-9505
SBabich@rentonrfa.org

If you have any questions or complaints, please contact the Plan Administrator listed under the Article titled: "General Information About Our Plan".

Filing a Complaint

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services; Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.



Governing Board Agenda Item

SUBJECT/TITLE: Resolution 2026-06: Bid Exemption for AI/HPC Hardware Procurement

STAFF CONTACT: Samantha Babich, Chief Administration Officer

SUMMARY STATEMENT:

This resolution authorizes Renton RFA to use the special market conditions bid exemption under RCW 39.04.280(2) and Procurement SOP 2310 to procure AI and high-performance computing (AI/HPC) hardware without the standard competitive quote or sealed bid process, given current severe supply and pricing volatility in the GPU/AI hardware market.

FISCAL IMPACT:

Expenditure N/A Revenue N/A
Currently in the Budget Yes ☐ No ☐ N/A ☒

SUMMARY OF ACTION:

Staff recommends the Governance Board adopt Resolution 2026-06, authorizing use of the special market conditions bid exemption under RCW 39.04.280(2) for procurement of AI/HPC Hardware (servers, GPUs and other AI accelerators, storage systems, and directly associated infrastructure). Global supply constraints, vendor allocation limits, and rapid price escalation for this hardware currently make it impracticable to reliably complete a competitive quote or sealed bid process before available inventory is sold out or repriced. The exemption applies only to purchases already included in the Governance Board-approved budget and consistent with the purchasing authority thresholds in SOP 2310, Section 4.0, and remains in effect through December 31, 2027 unless earlier rescinded or extended. While the exemption is in effect, the Fire Chief or designee must make a written finding with each purchase confirming that these market conditions continue to preclude competitive bidding.

Reviewed by Legal Yes ☒ No ☐ N/A ☐

EXHIBITS:

1. Resolution No. 2026-06

RFA GOVERNANCE BOARD RECOMMENDED ACTION:

Move to adopt Resolution No. 2026-06, authorizing use of the special market conditions bid exemption for procurement of AI/HPC Hardware, as presented.

RENTON REGIONAL FIRE AUTHORITY

RESOLUTION NO. 2026-06

AUTHORIZING USE OF A SPECIAL MARKET CONDITIONS BID EXEMPTION FOR THE PROCUREMENT OF ARTIFICIAL INTELLIGENCE AND HIGH-PERFORMANCE COMPUTING HARDWARE

WHEREAS, the Renton Regional Fire Authority (“Renton RFA”) relies on information technology infrastructure, including servers, storage, networking, and computing hardware, to support its operations, records management, dispatch and communications, data analysis, and emerging artificial intelligence applications; and

WHEREAS, RCW 52.14.110 and Renton RFA Procurement SOP 2310 generally require purchases of materials, equipment, and supplies to be made through competitive bidding, a designated purchasing cooperative, a cooperative purchase, or by obtaining at least three quotes, depending on the estimated cost of the purchase; and

WHEREAS, RCW 39.04.280(2) and Procurement SOP 2310, Section 6.1.4.2, establish an exemption from standard competitive bidding requirements for purchases involving special facilities or market conditions; and

WHEREAS, the global market for graphics processing units, artificial intelligence accelerators, servers, and related high-performance computing hardware is currently characterized by severe supply constraints, vendor allocation limits, rapid price escalation, and inventory that is frequently sold out or reallocated within days or hours of becoming available; and

WHEREAS, these market conditions make it impracticable for Renton RFA to reliably solicit and evaluate multiple written quotes, or to complete a formal sealed bid process, before the specific hardware needed becomes unavailable or is repriced; and

WHEREAS, the Governance Board finds that these are special market conditions within the meaning of RCW 39.04.280(2), comparable to conditions previously recognized by Washington public agencies for equipment subject to similarly volatile supply and pricing; and

WHEREAS, the Governance Board finds that it is in the public interest of Renton RFA to authorize a streamlined procurement process for such hardware, so that Renton RFA may act quickly to secure necessary computing equipment at competitive prices within its approved budget;

NOW THEREFORE, BE IT RESOLVED, that the Governance Board of the Renton Regional Fire Authority hereby finds that special market conditions exist for the procurement of artificial intelligence and high-performance computing hardware, including but not limited to servers, graphics processing units (GPUs) and other AI accelerators, storage systems, and directly associated infrastructure (“AI/HPC Hardware”); and

BE IT FURTHER RESOLVED, that pursuant to RCW 39.04.280(2) and Procurement SOP 2310, Section 6.1.4.2, the Governance Board authorizes Renton RFA staff to procure AI/HPC Hardware using a bid exemption in lieu of the competitive quote or formal sealed bid procedures otherwise required by Procurement SOP 2310, Section 5.2. provided that:

1. The purchase is included within Renton RFA’s Governance Board-approved budget for the applicable fiscal year; and
2. The purchase is approved consistent with the purchasing authority thresholds in Procurement SOP 2310, Section 4.0.

BE IT FURTHER RESOLVED, that this exemption shall remain in effect through December 31, 2027, unless earlier rescinded or extended by the Governance Board, in recognition that the market conditions described above are expected to evolve and that continued use of this exemption should be periodically reviewed.

BE IT FURTHER RESOLVED, that while this Resolution is in effect, the Fire Chief or designee shall make a written finding each time a purchase made under this exemption that the market conditions described above continue to preclude the use of competitive bidding.

ADOPTED by the Governance Board of the RENTON REGIONAL FIRE AUTHORITY at an open public meeting of such Board on the 14th day of September, 2026, the following Members being present and voting:

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member