MULTNOMAH BAR ASSOCIATION
GROUP HEALTH INSURANCE PLAN AND TRUST

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ARTICLE 1

General

1.1 Establishment of Plan. Multnomah Bar Association ("MBA"), in its role as Plan Sponsor, establishes and maintains this Multnomah Bar Association Group Health Insurance Plan and Trust (the "Plan") for the benefit of eligible employees of Participating Employers and in accordance with the provisions of ERISA, the Code and other provisions of law pertaining to employee benefit plans.

1.2 Employer Interest. The Board of Trustees, the members of which will be elected as prescribed in Article 8, will serve as the Plan Administrator, and will act in the interest of an employer in relation to the Plan.

1.3 Plan Benefits. The Plan is established and will be maintained to provide employee welfare benefits for eligible employees and their respective dependents through one or more welfare benefit programs. Such benefits may include medical, surgical, hospital care, dental, vision and prescription drug coverage.

1.4 Status of Plan. The Plan is expressly intended to qualify as:

(a) An "employee welfare benefit plan" within the meaning of ERISA Section 3(1); and

(b) A "fully insured multiple employer welfare arrangement" within the meaning of ERISA Section 514(b)(6)(A)(i).

1.5 Composition of Plan. The Plan document is a compilation of a number of separate documents, including insurance contracts, administrative service agreements, summary plan descriptions and employee benefit booklets. An individual's entitlement to coverage under the Plan, and any Benefit Program of the Plan, and the amount of any benefits provided under the Benefit Program, will be as set forth in the insurance contract, administrative services agreement, summary plan description or employee benefits handbook through which such benefits are administered.

1.6 Scope of Plan Coverage. The Plan and any Benefit Program associated with the Plan will cover those groups of individuals identified by the particular Benefit Program as being covered; provided, however, no former employee of a Participating Employer, or the spouse or dependents of a former employee, will be deemed covered by any Benefit Program unless such Benefit Program expressly covers the individual as a former employee, or as a beneficiary of a former employee, such in the case of COBRA continuation coverage.

1.7 Source of Benefits. All benefits provided under the Plan will be provided and guaranteed under contracts or policies of insurance issued by an Insurer or insurance organization (such as a "Health Maintenance Organization") qualified to conduct business in a state.

1.8 Source of Funds. The Plan and its associated Benefit Programs will be funded and maintained by contributions from the Participating Employers, Participants, and dependents to the extent described in each such Benefit Program.

1.9 Exclusive Purpose. Upon the transfer by a Participating Employer of any funds to the Plan in accordance with the provisions of this Plan, all interest of the Participating Employer therein will cease and terminate, and no part of the Plan will be used for, or diverted to, purposes other than the exclusive benefit of Participants and their dependents and the defrayal of reasonable expenses of administering the Plan and Trust.

1.10 Workers' Compensation Not Affected. This Plan is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

1.11 Preemption of State Law. The Plan is intended to provide benefits which may or may not be subject to the requirements of ERISA. To the extent that the Plan or a component thereof is governed by ERISA, state law will be preempted to the fullest extent permitted by law. To the extent that any component or feature of the Plan has characteristics with respect to which ERISA's preemptive effect is not applicable, then for purposes of ERISA that component or feature will be deemed to be separate and will not diminish the preemptive effect of ERISA with respect to any other component or feature of the Plan.

1.12 Effective Date. The provisions of this Plan document as prescribed herein are effective as of April 1, 2014.

ARTICLE 2

Definitions

Where the following words and phrases appear in this Plan, they will have the respective meanings set forth below, unless their context clearly indicates otherwise.

ACA. "ACA" means the Affordable Care Act, as amended.

Benefit Program. "Benefit Program" means a program of qualified benefits that forms part of this Plan.

Board of Trustees. "Board of Trustees" means the Board of Trustees of the Multnomah Bar Association Group Health Insurance Plan and Trust described in Article 8.

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

Contract Year. "Contract Year" means the annual renewable period for which a Participating Employer is enrolled in a Benefit Program. A Contract Year may be the Plan Year, a fiscal year beginning on April 1, or such other annual period prescribed under the particular Benefit Program.

Eligible Employee. An "Eligible Employee" is an employee of a Participating Employer who has satisfied the employment standards established by the Participating Employer for enrollment in the Plan.

Eligible Employer. "Eligible Employer" means an employer that satisfies the eligibility standards prescribed in Section 3.1.

Employee. "Employee" means a common law employee of a Participating Employer. It also means a partner, owner or other self-employed individual who is treated as an employee of the Participating Employer pursuant to Code Section 401(c)(1). However, the term "Employee" will expressly exclude as with respect to any period a leased employee, an independent contractor, or any other individual performing services for a Participating Employer who for the period at issue had not been treated by the Participating Employer as either a self-employed individual as described above or as an employee for employment tax purposes.

ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as from time to time amended.

GINA. "GINA" means the Genetic Information Nondiscrimination Act of 2008.

Group Health Benefit Program. A "Group Health Benefit Program" means a Benefit Program providing health care coverage.

HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Policy. "Insurance Policy" means a written contract, policy or other agreement issued by an Insurer or insurance organization (including a Health Maintenance Organization) through which benefits are insured and guaranteed. All benefits under the Plan will be provided by an Insurance Policy. Each Insurance Policy maintained in connection with the Plan or a Benefit Program will form part of the Plan and is incorporated herein by reference.

Insurer. "Insurer" means an organization licensed under applicable law to issue insurance contracts or policies. As used in the Plan, the term "Insurer" will also be deemed to mean a Health Care Service Contractor.

MBA. "MBA" means Multnomah Bar Association.

Participant. A "Participant" is (a) a current Employee of a Participating Employer who has become eligible to participate in the Plan pursuant to the terms of a Benefit Program, or (b) a former Employee who remains eligible for coverage under the Plan (such as a former Employee who is receiving COBRA continuation coverage benefits under the Plan).

Participating Employer. "Participating Employer" means an Eligible Employer that has elected to participate in the Plan in accordance with the provisions prescribed in Article 3.

Plan. "Plan" means the Multnomah Bar Association Group Health Insurance Plan and Trust, and all documents, including any insurance contracts, administrative service agreements, summary plan descriptions, employee benefit booklets and any related terms and conditions associated with the Plan.

Plan Administrator. The Board of Trustees will serve as the "Plan Administrator."

Plan Sponsor. MBA is the "Plan Sponsor" of the Plan.

Plan Year. For purposes of the Plan itself, a "Plan Year" is the 12-month period beginning on April 1 and ending on March 31 of each year. In the context of any specific Benefit Program, a "Plan Year" may also mean any annual period expressly designated under the Benefit Program that is utilized for administrative or coverage purposes. No dates of expiration, policy year or other period of coverage contained in any insurance contract will have any effect on the Plan Year.

Trust Agreement. "Trust Agreement" means the trust provisions of the Plan set forth in Articles 8, 9 and 11, as amended from time to time.

Trustees. "Trustees" mean the Trustees described in Article 8.

ARTICLE 3

Participating Employers

3.1 Eligible Employers. Participation in the Plan is restricted to the following classes of employers:

(a) MBA;

(b) Law firms which have attorneys who are members of the MBA; and

(c) Other organizations involved in the legal profession which the Board of Trustees determines have a commonality of interest with the participating law firms.

3.2 Participation Requirements. In order to qualify as a Participating Employer, an Eligible Employer must satisfy the conditions prescribed below.

(a) The Participating Employer must have at least one common-law employee enrolled in the Plan at all times.

(b) A partnership or sole proprietorship is not precluded from becoming a Participating Employer, nor are partners or sole proprietors precluded from becoming Participants in the Plan. However, in order to qualify as a Participating Employer, a partnership or sole proprietorship must also have at least one common-law employee (other than or in addition to a spouse of a partner or sole proprietor) enrolled in the Plan.

(c) The Participating Employer must have a physical presence in Oregon or a contingent state.

(d) If requested by the Plan Administrator, an employer will be required to provide evidence of its employer status (for example, by providing a copy of its Oregon Form 132 (Wage Detail Report)) as a condition to its becoming or continuing as a Participating Employer under the Plan.

(e) Each Participating Employer must maintain workers' compensation coverage on behalf of all of its Eligible Employees, unless the employee is exempt from occupational coverage.

(f) The Board of Trustees may adopt an administrative rule that requires a minimum percentage of each Participating Employer's Eligible Employees, or of the eligible dependents of such Eligible Employees, to enroll in a Benefit Program under the Plan. For purposes of computing this enrollment threshold, the administrative rule may provide that individuals who provide evidence of other qualifying health coverage (including, for example, group or personal comprehensive health coverage, Medicare or Medicaid) will not be taken into account.

3.3 Adoption of Plan. An Eligible Employer may adopt the Plan and any available Benefit Programs hereunder for the benefit of its Eligible Employees by execution of such documents as will be provided to such Eligible Employer by the Plan Administrator or its delegate. Upon the effective date of initial enrollment of the Eligible Employer's Eligible Employees in the Plan, the Eligible Employer will be deemed to be a Participating Employer.

3.4 Nonpayment of Premiums. The Plan participation rights of a Participating Employer that fails to timely pay its required contributions under the Plan, or under any Benefit Program, will be subject to rescission. Such rescission will be subject to and consistent with the issuance of advance notice of such impending cancellation of coverage, and the reinstatement of such coverage, as may be required under the ACA and state insurance laws and regulations. In addition, a Participating Employer will be subject to applicable late payment and reinstatement fees as in effect from time to time under the Plan and applicable Benefit Programs.

3.5 Fraud or Misrepresentations.

(a) A Participating Employer that commits a fraud or makes a misrepresentation of a material fact with respect to matters relating to or implicating the Plan or the benefits provided thereunder will lose its participation rights under the Plan.

(b) A Participating Employer will also cease to be eligible for participation rights under the Plan if it fails to comply with a material provision of the Plan or any Benefit Program.

(c) Any individual who commits a fraud or makes a misrepresentation of a material fact will similarly lose his or her coverage under the Plan.

3.6 Failure to Meet Eligibility Requirements. A Participating Employer that is found to have ceased to satisfy the eligibility requirements prescribed under Section 3.1 will be provided written notice from the Plan Administrator of such determination. Such employer will thereupon cease to be eligible for participation rights under the Plan effective as of the first day of the month coincident with or next following the thirtieth day after such notice is mailed or otherwise provided by the Plan Administrator. Such employer may again become a Participating Employer as of the commencement of any future Contract Year, provided that it then again satisfies the eligibility requirements.

3.7 Cessation of Benefit Offering. The Plan participation rights of a Participating Employer may be rescinded if the Plan ceases to offer any coverage in the geographic area (or, in the case of a network plan, in the network service area) where individuals enrolled through the Employer predominately reside or work.

3.8 Voluntary Withdrawal. A Participating Employer may withdraw from the Plan by providing reasonable advance written notice to the Plan Administrator. Upon such withdrawal, coverage under the Plan with respect to the Participating Employer's covered employees and dependents will cease as of the last day of the month for which the applicable premium has been paid.

ARTICLE 4

Plan Contributions

4.1 Employer Contributions.

(a) Each Participating Employer will make continuing and proper payments to the Plan as required by and in accordance with the terms of the Benefit Program to which such Participating Employer is a party.

(b) Upon payment to the contributions to the Plan as prescribed in subsection (a) above, all responsibilities of each Participating Employer for its contributions will cease. No Participating Employer will be liable for contributions required to be made by another Participating Employer and, subject to timely payment of its required contributions, a Participating Employer will have no liability for funding or paying the benefits provided under the Plan.

4.2 Participant Contributions.

(a) As a condition to coverage under a Benefit Program, a Participant may be required to contribute toward the cost of the coverage under such program. The amount of such contribution will depend on the Benefit Program selected, and, if applicable, the coverage category selected. The contribution rates for each year will be established by the Plan Sponsor. Participant contribution rates may differ for different classes or groups of Employees.

(b) The Pre-Tax Premium Arrangement reduces a Participant's compensation by the amount that the Participant would otherwise be required to pay as a condition of coverage under the Group Health Benefit Programs, and applies such reduction amount on a pre-tax basis toward the payment of the applicable premium contributions. For each Group Health Benefit Program for which a Participant is required to make a contribution as a condition to coverage, the Participant is required to make the applicable contributions on a pre-tax basis through the Pre-Tax Premium Arrangement unless not permitted to do so by the Code, or the Participant's Participating Employer, in its discretion and on a nondiscriminatory basis, requires or allows Participants to make the contributions on an after-tax basis.

(c) All cost-sharing contributions withheld by or otherwise remitted to a Participating Employer (including any COBRA continuation coverage premiums) will be remitted by the Participating Employer to the Plan as soon as practicable, and in all events, within 90 days of the date such contributions are received by the Participating Employer and can otherwise be segregated from the Participating Employer's general assets.

ARTICLE 5

Special Group Health Benefit Program Coverage Rules

5.1 COBRA Continuation Coverage. Under certain circumstances, Participants and their covered dependents have the right to continue coverage under a Group Health Benefit Program beyond the time coverage would ordinarily have ended. The rights and obligations regarding continuation of coverage are governed by COBRA and applicable state laws. The terms and conditions of such continuation coverage will be prescribed in the benefit booklets for the applicable Group Health Benefit Program. The continuation coverage provisions of such booklet will form part of the Plan and are hereby incorporated by reference.

5.2 USERRA Continuation Coverage. A Participant who leaves the employment of MBA to perform services in the Armed Forces or another uniformed service, and who would then otherwise cease to be eligible for coverage under the Group Health Benefit Program, can elect continuation coverage that is made available pursuant to the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). The terms and conditions of such continuation coverage will be prescribed in the benefit booklets for the applicable Group Health Benefit Program. The continuation coverage provisions of such booklet will form part of the Plan and are hereby incorporated by reference.

5.3 Special ERISA Rules. Notwithstanding any provision of a Group Health Benefit Program to the contrary, the following ERISA Sections 609(b), (c) and (d) rules will apply to the extent required by law.

(a) Payment for benefits with respect to a Participant under a Group Health Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such Participant or a covered dependent, as required by a State Medicaid Plan. The rules set forth below should also apply.

(i) The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan will not be taken into account in regard to the individual's enrollment as a Participant or dependent, or in determining or making any payments for benefits of the individual as a person covered under the Group Health Benefit Program.

(ii) Payment for benefits under the Group Health Benefit Program will be made to a state in accordance with any state law which provides that the state has acquired the rights with respect to a Participant for items or services constituting medical assistance under a State Medicaid Plan.

(iii) For purposes of this subsection (a), a "State Medicaid Plan" means a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

(b) A Group Health Benefit Program will provide health benefits to dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants under the Group Health Benefit Program, regardless of whether the adoption has become final. In addition, the Group Health Benefit Program will not restrict health benefit coverage of any dependent child adopted by a Participant, or placed with a Participant for adoption, solely on the basis of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the Group Health Benefit Program. The foregoing will apply, however, only if the adoption or placement occurs while the Participant is eligible for coverage under a Group Health Benefit Program.

(c) For purposes of this subsection (b) above:

(i) The term "child" means, in connection with any adoption or placement for adoption of the child, an individual who has not attained age eighteen (18) as of the date of such adoption or placement for adoption.

(ii) The term "placement, or being placed for adoption" in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

5.4 Mental Health and Substance Use Disorder Parity.

(a) General Parity Requirement. A Group Health Benefit Program that provides both medical and surgical benefits and mental health or substance use disorder benefits may not apply any Financial Requirement or Treatment Limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant Financial Requirement or Treatment Limitation of that type applied to substantially all medical and surgical benefits in the same classification. Whether a Financial Requirement or Treatment Limitation is a predominant Financial Requirement or Treatment Limitation that applies to substantially all medical and surgical benefits in a classification is determined separately for each type of Financial Requirement or Treatment Limitation. The applicable classifications, and the application of the foregoing rules, will be determined in accordance with 29 CFR 2590.712.

(b) Nonquantitative Treatment Limitations. Except as otherwise prescribed by applicable regulations, a Group Health Benefit Program may not impose a nonquantitative Treatment Limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the Group Health Benefit Program as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative Treatment Limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical and surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. For purposes of the foregoing, nonquantitative Treatment Limitations include:

(i) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(ii) Formulary design for prescription drugs;

(iii) Standards for provider admission to participate in a network, including reimbursement rates;

(iv) Methods for determining usual, customary, and reasonable charges;

(v) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective; and

(vi) Exclusions based on failure to complete a course of treatment.

(c) Definitions. For purposes of this Section 5.4, the following terms will have the respective meanings set forth below:

(i) "Financial Requirement" means deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(ii) "Treatment Limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment Limitations include both quantitative Treatment Limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative Treatment Limitations, which otherwise limit the scope or duration of benefits for treatment under a Group Health Benefit Program. A permanent exclusion of all benefits for a particular condition or disorder is not a Treatment Limitation.

(d) Disclosure of Information on Medical Necessity. The criteria for determinations of medical necessity made under a Group Health Benefit Program with respect to mental health or substance use disorder benefits will be made available to any current or potential Participant, covered dependent, or contracting provider upon request to the Plan Administrator. The reason for any denial under the Group Health Benefit Program of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant or covered dependent will be made available to the Participant or dependent.

5.5 Affordable Care Act Provisions. The provision of this Section 5.5 apply to each Group Health Benefit Program (other than a program providing excepted benefits as defined under ERISA § 733(c)).

(a) Coverage of Adult Children. A Group Health Benefit Program that offers coverage for children will allow the coverage of a child who has not attained age 26.

(b) Prohibition of Pre-Existing Condition Exclusions. A Group Health Benefit Program may not impose a pre-existing condition exclusion with respect to any individual, regardless of age. For this purpose, a "pre-existing condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or, if coverage is denied, the date of denial), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. A pre-existing condition exclusion further includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to the individual's health status before the individual's effective date of coverage (or, if coverage is denied, the date of the denial) under the Group Health Benefit Program, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or a review of medical records relating to the pre-enrollment period.

(c) No Lifetime or Annual Limits. Except as may be permitted by applicable regulations, a Group Health Benefit Program may not, with respect to any individual, impose any lifetime limit, or any annual limit, on the dollar amount of a covered benefit that is an "essential health benefit" (as defined under Section 1032(b) of ACA).

(d) Prohibition of Rescissions. Once the coverage of an individual under a Group Health Benefit Program has become effective, the coverage may not be rescinded unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of a material fact.

(i) A Participant whose coverage (or whose dependent's coverage) is to be rescinded pursuant to the above must be provided at least 30 days advance written notice of the rescission.

(ii) For purposes of the above, a "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A rescission does not mean a cancellation or discontinuance of coverage that:

(A) Has only a prospective affect; or

(B) Is effective retroactively, to the extent that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(e) Designation of Primary Care Provider. If a Group Health Benefit Program requires or provides for the designation by a Participant or dependent of a participating primary care provider, then each Participant or dependent may designate any primary care provider who is available to accept the Participant or dependent.

(f) Designation of Pediatrician. If a Group Health Benefit Program requires or provides for the designation of a participating primary care provider for a child by a Participant or dependent, the Participant or dependent, as the case may be, may designate a physician who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the Group Health Benefit Program and is available to accept the child.

(g) Access to Obstetrical and Gynecological Care. A Group Health Benefit Program may not require authorization or referral for obstetrical and gynecological care to be provided by a participating health care professional who specializes in obstetrics or gynecology.

(h) Coverage of Emergency Services. If a Group Health Benefit Program provides any benefits with respect to services in an emergency department of a hospital, then the program must provide coverage for emergency services:

(i) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(ii) Without regard to whether the health care provider furnishing the emergency room services is a participating network provider with respect to the services;

(iii) If the emergency services are provided out-of-network, without imposing any administrative requirements were limitation of coverage that is more restrictive than the requirements and limitations that apply to emergency services received from in-network providers; and

(iv) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of applicable federal regulations.

(i) Preventive Health Services.

(i) Except as otherwise provided under applicable regulations, a Group Health Benefit Program must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as co-payment, co-insurance or deductible) with respect to those items or services:

(A) Evidenced-based items or services that have been in effect a rating of A or B in the current recommendations of the United States Preventative Services Task Force with respect to the individual involved;

(B) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

(C) With respect to infants, children and adolescents, and with respect to women, evidence-informed preventative care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(ii) The foregoing provisions do not:

(A) Require that a Group Health Benefit Program that has a network of providers cover any benefits for items and services described above that are delivered by an out-of-network provider;

(B) Prevent the program from imposing cost-sharing requirements for items and services described above that are delivered by an out-of-network provider.

(iii) Reasonable medical management techniques may be used under a Group Health Benefit Program to determine the frequency, method, treatment or setting for an item or service described above, to the extent not specified in the applicable recommendation or guideline.

(j) Out-of-Pocket Maximums. The cost-sharing imposed under the Plan for any Plan Year with respect to any essential health benefits (within the meaning of Section 1302(b) of the ACA) may not exceed the dollar limits prescribed under Code Section 223(c)(2)(A)(ii), as adjusted by Section 1302(c)(1)(B). For this purpose, "cost-sharing" includes deductibles, co-insurance, co-payments and any other expenditure required of an individual which is a qualified medical expense with respect to an essential health benefit.

(k) Coverage for Individuals Participating in Approved Clinical Trials. The following will be applicable, notwithstanding any provision of the Plan to the contrary.

(i) The Plan:

(A) May not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;

(B) May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) May not discriminate against the individual on the basis of the individual's participation in the trial.

(ii) A "qualified individual" is a Participant or dependent who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either:

(A) The referring health care professional is a participating provider and has concluded that the individuals' participation in such trial would be appropriate; or

(B) The Participant or dependent provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(l) Provider Non-Discrimination. The Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. The foregoing will not restrict the Plan from establishing varying reimbursement rates based on quality or performance measures.

ARTICLE 6

Privacy and Security Rules

6.1 HIPAA Privacy and Security.

(a) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations include provisions designed to protect the privacy of health information concerning individuals covered under a group health plan. However, these laws recognize that MBA and the Participating Employers, and certain of their employees, may have the need for access to, and the use of, such health information in order to perform administration functions with respect to the plan. The laws thus permit the use and disclosure of such health information by MBA and the Participating Employers, and their designated employees, subject to prescribed restrictions that are required to be expressly identified and acknowledged in the governing plan document. Toward that end, the use or disclosure of protected health information of persons covered under the Group Health Benefit Program will be subject to the terms and conditions prescribed in this Article 6.

(b) The Plan is a hybrid plan consisting of Benefit Programs that provide group health benefits and Benefit Programs that provide other forms of benefit. The HIPAA Privacy and Security Rules apply solely to health plans. Accordingly, as used in this Article 6, the term "Plan" refers only to a Benefit Program under the Plan that provides group health benefits and is otherwise deemed to be a health plan for purposes of the HIPAA Privacy and Security Rules.

6.2 Definitions. When used in this Article 6, certain terms have the respective meanings set forth in this Section 6.2, or in certain other Sections of this Article 6.

(a) Covered Individual. "Covered Individual" means a person who is covered under a Group Health Benefit Program and who is the subject of the PHI at issue.

(b) HIPAA Privacy Rules. "HIPAA Privacy Rules" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

(c) Plan Administration Functions. "Plan Administration Functions" means any function or activity that MBA or a Participating Employer performs on behalf of a Group Health Benefit Program.

(d) Protected Health Information (PHI). "Protected Health Information" or "PHI" means with respect to any Covered Individual any information (including information of persons living or deceased) that:

- Is created or received by the Plan;
- Relates to the past, present, or future physical or mental health or condition of the Covered Individual, the provision of health care to the

Covered Individual, or the past, present or future payment for the provision of health care to the Covered Individual; and

- Identifies the Covered Individual, or for which there is a reasonable basis to believe the information can be used to identify the Covered Individual.

(e) Security Rules. "Security Rules" will mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

6.3 Plan Restrictions. Notwithstanding any provision of the Plan to the contrary, the Plan will not:

(a) Disclose a Covered Individual's PHI to MBA or a Participating Employer to carry out Plan Administration Functions that MBA performs on behalf of the Group Health Benefit Program, except to the extent consistent with the provisions of the HIPAA Privacy Rules;

(b) Permit a health insurance issuer with respect to the Group Health Benefit Program to disclose a Covered Individual's PHI to MBA or a Participating Employer, except as permitted by the HIPAA Privacy Rules;

(c) Disclose nor permit a health insurance issuer to disclose a Covered Individual's PHI to MBA or a Participating Employer as otherwise permitted by the Privacy Rules, unless covered employees are provided a Notice of Privacy Practices that advises of such permissive disclosures; and

(d) Disclose a Covered Individual's PHI for the purpose of employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of MBA or a Participating Employer.

6.4 GINA Privacy. The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits a group health plan from discriminating in regard to health insurance premiums on the basis of genetic information. GINA further places limitations on the authority of group health plans to request genetic testing and collect genetic information. It is the intention of MBA that the Plan acknowledge and fully comply with the group health plan provisions of GINA. Toward that end, each Group Health Benefit Program maintained under the Plan will be subject to the terms and conditions prescribed in this Section 6.4.

(a) Prohibited Discrimination in Premiums or Contributions. In general, the amount of the premiums or contributions otherwise payable by members of, or with respect to, any group covered under a Group Health Benefit Program may not be adjusted on the basis of genetic information. The foregoing prohibition does not restrict a health insurance issuer offering health insurance coverage in connection with a Group Health Benefit Program from increasing the premium or contribution due to the manifestation of a disease or disorder of an individual covered under the Group Health Benefit Program. However, the manifestation with respect to one individual cannot be used as genetic information about other covered individuals to further increase the premium for the covered group.

(b) Restriction on Genetic Testing.

(i) The Plan will not require or request an individual who is enrolled in, or who is eligible to be enrolled in, a Group Health Benefit Program, or a family member of any such individual, to undergo a genetic test. However, a health care professional providing health care services to an individual is free to recommend that such individual undergo a genetic test.

(ii) Notwithstanding paragraph (i) above, the Plan is not prevented from obtaining and using the results of a genetic test in making a payment determination under a Group Health Benefit Program, but only if it requests no more than the minimum amount of information necessary to accomplish the intended purpose.

(c) Restriction on Collection of Genetic Information.

(i) The Plan may not request, require, or purchase genetic information for Underwriting Purposes.

(ii) Except as provided in Section 6.5 below, the Plan also may not request, require or purchase genetic information with respect to any Participant or dependent prior to, or in connection with, the individual's enrollment under the Group Health Benefit Program, provided, however, that if the Plan obtains genetic information incidental to obtaining other information concerning any individual and if that information is not used for underwriting purposes, such acquisition will not be considered a violation of this subsection (b).

6.5 Voluntary Wellness Programs.

(a) The restriction on the requesting, requiring or purchasing of genetic information of any individual prescribed in Section 6.4(b) above does not apply for services offered as part of a voluntary wellness program; provided that:

(i) The provision of genetic information by the individual is voluntary, meaning the wellness program neither requires the individual to provide genetic information nor penalizes those who choose not to provide it;

(ii) The individual provides prior knowing, voluntary, and written authorization, which may include authorization in electronic format. This requirement is only met if the wellness program uses an authorization form that:

(A) Is written so that the individual from whom the genetic information is being obtained is reasonably likely to understand it;

(B) Describes the type of genetic information that will be obtained and the general purposes for which it will be used; and

(C) Describes the restrictions on disclosure of genetic information.

(iii) Individually identifiable genetic information is provided only to the individual (or family member if the family member is receiving genetic services) and the licensed health care professionals or board certified genetic counselors involved in providing such services, and is not accessible to managers, supervisors, or others who make employment decisions, or to anyone else in the workplace; and

(iv) Any individually identifiable genetic information provided under this exception is only available for purposes of such services, and is not disclosed to an employer, except in aggregate terms that do not disclose the identity of specific individuals.

(b) A wellness program may not offer a financial inducement for individuals to provide genetic information.

(c) A wellness program may offer financial inducements to encourage individuals who have voluntarily provided genetic information (e.g., family medical history) that indicates that they are at increased risk of acquiring a health condition in the future to participate in disease management programs or other programs that promote healthy lifestyles, or to meet particular health goals as part of a health or genetic service. However, these programs must also be offered to individuals with current health conditions, and to individuals whose lifestyle choices put them at increased risk of developing a condition.

(d) The scope of the exception prescribed in this Section 6.5 does not limit the rights or protections of an individual under the Americans with Disabilities Act, as amended, or other applicable civil rights laws, or under HIPAA, as amended by GINA.

ARTICLE 7

Claims Administration and Disputes

7.1 Terms of Benefit Program. The amount of the benefits provided under any Benefit Program, and other terms and conditions of the program as in effect for any period, will be as set forth in the Insurance Policy and other documents through which such benefits are administered. Such Insurance Policy will form part of the Plan. If the terms of the Insurance Policy and other documents, and of this Plan, conflict in regard to an individual's entitlement to coverage or benefits under the Benefit Program, the terms of the Insurance Policy and other documents will govern.

7.2 Claims for Benefits. A person's entitlement to a benefit under a Benefit Program will be determined by the Insurer in accordance with the provisions of the underlying Insurance Policy.

7.3 Discretionary Authority. The Insurer with respect to a Benefit Program is expressly reposed with the discretionary authority and powers in regard to all facets of any claims for benefits and requests for prior authorization made under the Benefit Program. Similarly, the Insurer of the Benefit Program is expressly reposed with discretionary authority and powers to consider and decide appeals of any such claims or requests that have been denied under the Benefit Program. The scope of such discretionary authority and powers include, but are not limited to, the following:

(a) Construing and interpreting the terms of the Benefit Program and of any documents pertaining to the Benefit Program;

(b) Construing and interpreting all laws and regulations as applicable to any claims for benefits made under the Benefit Program;

(c) Making any factual determinations, and applying such determinations to the terms of the Benefit Program and issues arising under the Benefit Program;

(d) Making a determination as to an individual's status as an Employee, Participant or beneficiary within the meaning of the Benefit Program; and

(e) Otherwise deciding all questions regarding an individual's benefit entitlements under the Benefit Program, and the manner and timing of any payments to be made to or with respect to any individual under the Benefit Program.

In all regards, benefits under a Benefit Program will be paid only if the Insurer decides in its discretion that the claimant is entitled to such benefit.

7.4 No Verbal Modifications of Plan Provisions. No verbal statement made by anyone involved in administering this Plan can waive any of the terms or conditions of this Plan or prevent the Plan Administrator from enforcing any provision of this Plan. Waivers are valid only if they are contained in a written instrument signed by an authorized individual on behalf of the Plan Administrator. Any such written waiver will be valid only as to the specific plan, term or condition set forth in the written instrument. Unless specifically stated otherwise, a written waiver will be valid only for the specific claim involved at the time, and will not be a continuing waiver of the term or condition in the future.

ARTICLE 8

Board of Trustees

8.1 Qualification of Trustees. The Board of Trustees (the "Board") will have no fewer than five, and no more than fifteen, Trustees appointed by the Participating Employers. No person will be disqualified from being a Trustee by reason of the fact that such person is or hereafter becomes a Participant in the Plan. Each Trustee will consent to and accept his or her appointment as a Trustee in writing. Each Trustee will continue to serve during the existence of the Plan until such individual's death, incapacity, resignation or removal. The Participating Employers may, from time to time, increase or decrease the number of required Trustees.

8.2 Officers of Trustees. The Trustees may from time to time select from among them a Chair and a Secretary/Treasurer.

8.3 Resignation of a Trustee. A Trustee may resign and subsequent thereto will be discharged from any further duty or responsibility hereunder by giving prior written notice to the Chair or Secretary/Treasurer of the Board of Trustees. Such resignation will take effect upon the delivery of such notice of resignation or as of such later date so specified in the notice. A Trustee, upon leaving office, will promptly turn over and deliver to the Board any and all property in such person's possession or under such person's control which belongs to the Plan.

8.4 Removal of Trustees. Any Trustee may be removed from office at any time by a two-thirds vote of the other Trustees, or by a majority vote of the Participating Employers voting with respect to such action. Written notice of such removal will take effect as of the date specified in such notice, which date will not be less than thirty (30) days after the delivery of such notice (unless a successor Trustee will have been earlier appointed in accordance with Section 8.5 below).

8.5 Selection of Successor Trustees. If any Trustee will die, resign, be removed, become incapacitated or refuse to act, the Participating Employers may choose to appoint a successor Trustee, or may do so in order to meet the minimum member requirement prescribed in Section 8.1 above. A successor Trustee will be appointed by the Participating Employers in accordance with the following procedures.

(a) The Trustees will appoint a nominating committee composed of an officer or other representative of three (3) Participating Employers.

(b) The nominating committee will send a notice of the committee's nomination to all Participating Employers. Such notice will further advise of a Participating Employer's privilege to submit its own nomination.

(c) If no Participating Employer submits its own nomination within 30 days, then the nominating committee's candidate will be appointed as Trustee.

(d) If any Participating Employer submits its own candidate, then a ballot of all the nominated candidates will be sent to each Participating Employer. Each Participating Employer will have one vote. The candidate receiving the greatest number of votes will thereupon be appointed as Trustee.

8.6 Powers of Successor Trustee.

(a) Each successor Trustee will have, exercise and enjoy all of the powers, both discretionary and ministerial, herein conferred upon the predecessor Trustee.

(b) A successor Trustee will not be obliged to examine or review the accounts, records, and acts of or property delivered by any predecessor Trustee and will not be responsible for any action or any failure to act on the part of any predecessor Trustee.

ARTICLE 9

Organization and Operation of Trustees

9.1 Trustee Meetings.

(a) The Trustees will meet whenever required to provide for the orderly and timely administration of the business of the Plan at such location as may be acceptable to the Trustees. The Chair, Secretary/Treasurer or any two Trustees may call meetings of the Trustees. Any meeting will be called upon at least five days' written notice to all Trustees, which notice will specify the date, time and place of such meeting and may specify the purpose thereof and any action proposed to be taken thereat. Attendance at Trustees' meetings will be limited to the Trustees and other persons invited by the Trustees.

(b) Whenever any notice is required to be given to any Trustee hereunder, a waiver thereof in writing, signed at any time, whether before or after the time of meeting by the Trustees entitled to such notice, will be deemed equivalent to the giving of such notice. The attendance of a Trustee at a meeting or the Trustee's approval of the actions taken at a meeting at which the Trustee was not present will also constitute a waiver of any required notice, except where a Trustee attends a meeting and objects thereat to the transaction of any business because the meeting is not lawfully called or convened.

(c) The Trustees may participate in any meeting through the use of a conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. A Trustee's participation in a meeting by such means will constitute that Trustee's presence in person at the meeting.

9.2 Informal Action by Trustees. Any action which may be taken at a meeting of the Trustees may be taken without a meeting if before or after the action a consent in writing setting forth the action so taken will be signed by all of the Trustees then serving. Such written consent may be provided by email or other appropriate electronic delivery method.

9.3 Quorum. A simple majority of the Trustees then in office will be necessary to constitute a quorum for the transaction of business.

9.4 Voting. Except as may otherwise be specifically provided for herein, all actions by and decisions of the Trustees will be by votes cast by Trustees who are in attendance at a duly called meeting of the Trustees at which there is a quorum present. Actions at a meeting at which a quorum is present will be the acts of the Trustees if the votes cast favoring the action exceed the votes cast opposing the action. Each Trustee will have one vote. No Trustee may act by proxy with respect to any matter. Notwithstanding the foregoing, the unanimous written consent of the Trustees will be required for any action taken pursuant to Section 9.2.

9.5 Execution of Documents. The Trustees, by resolution, may authorize any Trustee or any joint group of Trustees, to execute any notice, certificate or other written instrument relating to the Plan or Trust and all persons, partnerships, corporations or associations may rely upon any such notice or instrument so executed as having been duly authorized and as binding on the Plan and the Trustees.

9.6 Compensation of Trustees. Trustees will receive no compensation for services as such, but may be reimbursed for any actual and necessary expenses incurred in performing services for the Plan or attending meetings of the Trustees.

ARTICLE 10

Operation and Administration of Plan

10.1 Plan Administration. The Trustees will have authority to and will be responsible for the operation and administration of the Plan, except insofar as any authority or responsibility is assigned or delegated to one or more other fiduciaries pursuant to the provisions of this Plan and Trust Agreement.

10.2 Plan Responsibilities. The Trustees will have full and complete authority and control over the Plan. In connection with their operation and administration of the Plan, unless the following responsibilities are allocated or delegated in accordance with the procedures set forth in subsections (f) and (g) of Section 10.3, the Trustees will:

(a) Formulate and adopt a program of benefits consistent with the purposes of the Plan. Such program of benefits will be described in an Insurance Policy, benefit schedules, employee benefit booklet or other form of written instrument;

(b) If appropriate, establish and maintain a funding policy and method consistent with the Plan's objectives and in accordance with any applicable law to the Plan;

(c) Maintain books of account, records and other data as may be necessary for the proper administration and operation of the Plan. All said books, records, and data will be available for inspection by authorized representatives of any Participating Employer; and

(d) Prepare, execute, file and retain a copy for the Plan records of all reports required by law or deemed by them to be necessary or appropriate for the proper administration and operation of the Plan.

10.3 Plan Powers. The Trustees will have such powers as may be necessary to discharge their responsibilities in managing and controlling the general operations and administration of the Plan. The Trustees will have full and complete authority and control with respect to the operations and administration of the Plan unless such authority or control is allocated or delegated by the Trustees in accordance with the procedures set forth in subsections (f) and (g) below. Any determination by the Trustees in the exercise of these powers will be binding on all persons. In addition to such other powers as are conferred by law or are set forth elsewhere in this Plan and Trust Agreement, the powers of the Trustees in connection with their operation and administration of the Plan will include, but will not be limited to, the following:

(a) The Trustees will have full authority to determine all questions of any nature relating to the benefits to be provided under the Plan. In this regard, the Trustees are specifically empowered to:

(i) Establish Benefit Programs under the Plan, which Benefit Programs may be different as among various groups of current and former employees of the Participating Employers and their beneficiaries;

(ii) To take into account in establishing the Benefit Programs to be maintained the amount of contributions from the Participating Employers and Participants, the cost of providing benefits to any group, category or class of employees, and other factors that the Trustees in their discretion deem to be reasonable and appropriate; and

(iii) To combine or keep separate the claims experience of any group, category or class of employees, or of the employees of any Participating Employer or combination of Participating Employers, for the purpose of computing the cost of providing any benefits or for determining the type and amount of benefits to be made available to any group, category or class of employees.

(b) To determine the medium (i.e., Insurance Policy, Health Maintenance Organization or otherwise) by which benefits will be provided;

(c) To terminate a Participating Employer's participation in the Plan, in accordance with the procedures set forth in the Plan;

(d) To select, apply for, accept delivery of and act as policy holder under, any Insurance Policy purchased for the Plan, and to exercise all rights or privileges granted to a policy holder by the provisions of each policy or allowed by the Insurer of such policy, including the right to receive and hold as part of the Trust all dividends and experience rating refunds or reimbursements of any kind whatsoever, regardless of the designation thereof, made on any such policy, and to cancel any policy or policies of insurance which they have caused to be issued and may purchase in lieu thereof other like insurance from another Insurer or Insurers. The Trustees may agree with each Insurer upon all the provisions to be contained in each policy and to any alteration, modification or amendment of any policy. The Trustees may take any action respecting any policy or the insurance provided thereunder which may be necessary or advisable, in their sole judgment, and no Insurer will be required to inquire into the authority of the Trustees with regard to any dealings in connection with any policy. Any powers granted to the Trustees under this Plan and Trust Agreement with respect to an Insurer will extend to any Health Maintenance Organization providing benefits under the Plan;

(e) To employ such consultants, accountants, counsel or other persons as they deem necessary or desirable in connection with the administration of the Plan and Trust, and to employ one or more persons to render advice with regard to any responsibility or power of the Trustees. The costs of such services and other administrative expenses will be payable from the Trust Fund;

(f) To delegate in writing persons who are not Trustees to carry out fiduciary or nonfiduciary responsibilities or duties of the Trustees. In the event of any such delegation, the Trustees will not be liable for any act or omission of such a person;

(g) To allocate, in writing by unanimous consent, fiduciary or nonfiduciary responsibilities or duties among Trustees. Those persons to whom such responsibilities have not been allocated will not be liable for any act or omission of those persons to whom such responsibilities have been allocated;

(h) To receive from the Participating Employers, Participants or dependents such information as will be necessary for the proper administration of the Plan;

(i) To furnish the Participating Employers, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

(j) To enter into any and all contracts and agreements for carrying out the terms of this Plan, and for the administration and operation of the Plan, and to do all acts as they, in their discretion, may deem necessary or advisable, and such contracts and agreements and acts will be binding and conclusive on the parties hereto and on the Participants involved; and

(k) To do all acts, whether or not expressly authorized herein, which the Trustees may deem necessary or proper in connection with the Plan, although the power to do such acts is not specifically set forth herein.

10.4 Control of Plan. The Trustees will have the power to control the Plan and to perform all such acts, to take all such proceedings, and to exercise all such rights and privileges, although not specifically mentioned herein, as the Trustees may deem necessary or advisable to administer the Plan, or to carry out the purposes of this Plan.

10.5 Standards for Trustees' Powers. Notwithstanding any other provision of this Plan, the Trustees will exercise the powers granted to them herein:

(a) Solely in the interest of the Participants and their beneficiaries;

(b) For the exclusive purpose of providing benefits to Participants and their beneficiaries, and defraying reasonable expenses of administering the Plan and Trust;

(c) With the care, skill, prudence and diligence, which, under the circumstances then prevailing, 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

(d) By diversifying the investments of the Trust Fund so as to minimize the risk of large losses, unless, under the circumstances, it is clearly prudent not to do so.

10.6 Amendment or Termination of Plan.

(a) The Board of Trustees reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan, or any document forming part of the Plan.

(b) Any amendment, modification, supplement agreement or termination of the Plan or any part of the Plan will be made by an instrument in writing reflecting that such change has been authorized by the Board of Trustees. Any such amendment or termination will be effective as of the date specified in said instrument, or if no date is so specified, as of the date of execution or adoption of said instrument. An amendment may be effected by the establishment, modification, or termination of the Plan by appropriate action of Board of Trustees. Any such amendment or termination may take effect retroactively or otherwise. An instrument regarding the establishment, modification or termination of the Plan which is

executed by or ratified in writing by the Chair of the Board of Trustees will be conclusive evidence of the adoption and effectiveness of the instrument.

(c) No such amendment will enlarge the duties or responsibilities of the Trustees without their written consent thereto.

(d) In the event of a termination or reduction of benefits under the Plan, the Plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction, and no payments scheduled to be made on or after such effective date will result in any liability to the Plan, the Board of Trustees, MBA, the Participating Employer or any agent thereof.

ARTICLE 11

Miscellaneous

11.1 No Guarantee of Employment, etc. Neither the maintenance of the Plan nor any part thereof will be construed as giving any Participant or any other employee any right to remain in the employ of MBA or a Participating Employer. No shareholder, director, officer, or employee of MBA in any way guarantees to any individual the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

11.2 Benefits Not Transferable. The right to receive benefits under this Plan is not assignable or transferable to any other party. Any attempted assignment or transfer will not be binding on this Plan.

11.3 Recovery of Benefits Paid by Mistake. If payment is mistakenly made by the Plan for a covered individual to which that individual is not entitled, or if benefits are paid for an individual who is not eligible for benefits, MBA and the Plan have the right to recover the payment from the individual paid or anyone else who benefited from such payment, including a provider of services. The right to recovery includes the right of the Plan Administrator to deduct the amount paid by mistake from future benefits.

11.4 Controlling Law. To the extent not preempted by the laws of the United States of America, the laws of the State of Oregon will be the controlling state law in all matters relating to the Plan and will apply.

11.5 Severability. If any provisions of the Plan will be held illegal or invalid for any reason, said illegality or invalidity will not affect the remaining parts of the Plan, but the Plan will be construed and enforced as if said illegal and invalid provisions had never been included herein.

11.6 Limitations on Provisions. The provisions of the Plan and any benefits provided by the Plan will be limited as described herein. Any benefit payable under any other employee benefits plan maintained by a Participating Employer will be paid solely in accordance with the terms and provisions of such plan, and nothing in this Plan will operate or be construed in any way to modify, amend, or affect the terms and provisions of such other plan.

11.7 Election of Small Employer Exception. Unless the terms of an Insurance Policy or guidelines provide otherwise, pursuant to 42 USC §1395y(b)(1)(A)(iii), the Plan elects the exception from the Medicare secondary payer rules as otherwise applicable with respect to the coverage of a "working aged" under a group health plan. Accordingly, as with respect to any Contract Year as pertaining to a Benefit Program, the Plan will have secondary group health payer responsibility with respect to Participants and their dependents whose coverage under the Plan is by virtue of employment with a Participating Employer that, during both that Contract Year and in the preceding Contract Year, did not have 20 or more employees in each of 20 or more calendar weeks.

11.8 Liability of Participating Employers. The Participating Employers will not be responsible for the acts of the Plan Administrator or of the Trustees, or for the debts, liabilities, obligations or insufficiency of the Plan.

11.9 Nonalienation of Benefits. The Trust will not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person other than the Trustees and their duly authorized representatives, and then only to the extent and for the purposes as herein specifically provided, except that any Participant or dependent may assign any benefits to which such person may become entitled to a hospital, institution, or physician, or to any other provider of health care, as the case may be, in consideration of hospital or medical services rendered or to be rendered.

11.10 Gender and Number. Masculine gender will include the feminine and neuter, the singular will include the plural, and the plural will include the singular, unless the context clearly indicates otherwise.

11.11 Headings. All article and section headings in the Plan are intended merely for convenience and will in no way be deemed to modify or supplement the actual terms and provisions set forth thereunder.

11.12 Conflicts of Provisions. Except as otherwise provided, in the event that one or more provisions of this document conflict with one or more provisions of another Plan document, the provisions of this document, as from time to time amended, will control.

11.13 Counterparts. This Plan and Trust may be executed in any number of counterparts, each of which will be deemed an original, but all of which will constitute one and the same agreement.

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IN WITNESS WHEREOF, Multnomah Bar Association, as Plan Sponsor, has caused this Plan to be signed by its authorized officer, and the Trustees have signed the Plan, all effective as of April 1, 2014; the Trustees hereby evidencing their acceptance of the Plan, and their agreement to perform the duties given to or required of them by the Plan.

MULTNOMAH BAR ASSOCIATION

By: Richard J. Vangelisti
Richard Vangelisti, President

Dated: 2-14, 2014

TRUSTEES

Tony Walden	February 14, 2014 Date
[signature]	2/19/, 2014 Date
David O'B[signature]	2/19/, 2014 Date
[signature] Kennedy	February 24, 2014 Date
[signature]	2-27-2014, 2014 Date

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