HEALTH CARE PLAN

for

POLICE AND FIRE RETIREES OF THE CITY OF DETROIT

Adopted as of January 1, 2015
Amended and Restated as of December 16, 2024

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Preamble

WHEREAS, the City of Detroit, Michigan filed a voluntary petition for relief under Chapter 9 of the United States Bankruptcy Code on July 18, 2013, in the United States Bankruptcy Court for the Eastern District of Michigan (the "Court"); and

WHEREAS, the Court approved the Plan for the Adjustment of Debts of the City of Detroit (the "Plan of Adjustment") with an effective date of December 10, 2014; and

WHEREAS, the Plan of Adjustment provides for the establishment of a voluntary employees beneficiary association ("VEBA") to provide health care benefits to certain eligible City of Detroit retirees and their eligible dependents as of January 1, 2015; and

WHEREAS, the Plan of Adjustment established the City of Detroit Police and Fire Retiree Health Care Trust (the "Trust") as a vehicle for funding the benefits to be provided under the VEBA; and

WHEREAS, the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust is responsible for designing, adopting, maintaining and administering the Health Care Plan for Police and Fire Retirees of the City of Detroit (the "Plan"), through which all health care benefits to the Trust's beneficiaries shall be provided; therefore be it

RESOLVED, that THIS INSTRUMENT, as made and adopted by the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust effective the 1st day of January, 2015, is hereby amended and restated as of the 16th day of December, 2024, as follows:

ARTICLE I. ESTABLISHMENT

1.01 Purpose. The Plan and Trust taken as a whole shall constitute a voluntary employees beneficiary association under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended, and is created for the exclusive purpose of providing benefits for the welfare of certain police and fire retirees of the City of Detroit, and their eligible Dependents, through policies of insurance issued by duly licensed commercial insurance companies, through a fund of self-insurance, and/or through any other lawful means of providing group health coverage in accordance with applicable laws.

1.02 Name. This Plan shall be known as the Health Care Plan for Police and Fire Retirees of the City of Detroit.

1.03 Structure of the Plan. Benefits under the Plan will be provided to Participants through the purchase of insurance coverage, or by reimbursement of eligible medical expenses, in accordance will the Plan and applicable state and federal laws. The Board reserves the right to enter into Insurance Agreements, and to modify, alter or amend such agreements from time to time, with commercial insurance carriers, health maintenance organizations, preferred provider organizations or any other qualified entity currently existing or created for the purpose of providing benefits under the Plan.

ARTICLE II. DEFINITIONS

The following terms as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

2.01 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

2.02 "Adverse Benefit Determination" means a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a HRA benefit, including any such denial, reduction, termination, or failure that is based on a determination of a Participant's eligibility to participate in the Plan.

2.03 "Board" or **"Board of Trustees"** means the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust.

2.04 "City" means the City of Detroit, Michigan.

2.05 "Claim" shall mean a request for a Plan benefit, medical or other, or an eligibility request made by a Retiree or Spouse in accordance with the Plan's claims procedures.

2.06 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, as it applies through the Code and the Public Health Service Act.

2.07 "Code" means the Internal Revenue Code of 1986, as amended.

2.08 "Dependent" means any individual who is a legal dependent of the Participant within the meaning of Code section 152, without regard to subsections 152(b)(1), (b)(2), and (d)(1)(B) thereof, or an individual who was a legal dependent, within the meaning of Code section 152, without regard to subsections 152(b)(1), (b)(2), and (d)(1)(B) thereof, of a Participant immediately prior to the Participant's death and who would still qualify as a legal dependent of the Participant were the Participant still alive.

2.09 "Effective Date" means January 1, 2015.

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

2.11 "HMO" shall mean Health Maintenance Organization.

2.12 "HRA" shall mean the Health Reimbursement Arrangement offered to eligible Participants under the Plan.

2.13 "Insurance Agreement" means the health insurance plan(s) and any amendment(s) thereto, including any substitute insurance agreement with a commercial insurance carrier, health maintenance organization, preferred provider organization, or any other qualified entity currently existing or created for the purpose of providing benefits under the Plan.

2.14 "Insurance Carrier" means a commercial health insurance carrier, health maintenance organization, preferred provider organization or other qualified entity designated by the Board to provide benefits under the Plan.

2.15 "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

2.16 "Participant" means any eligible Retiree or eligible Spouse, who is eligible to participate under Section 3.01 of the Plan and is participating in the Plan pursuant to Section 3.02.

2.17 "Plan" or "RHC Plan" means the Health Care Plan for Police and Fire Retirees of the City of Detroit and any subsequent amendments, Insurance Agreement(s), or other applicable insurance policy documents incorporated by reference into the Plan.

2.18 "Plan Administrator" means the person(s) or entity(ies) designated by the Board to carry out the administrative services that are necessary to operate and administer the Plan.

2.19 "Plan of Adjustment" shall mean the Eighth Amended Plan for the Adjustment of Debts of the City of Detroit.

2.20 "Plan Year" means the 12-consecutive month period that begins on 1st day of January, and ends on the 31st day of December of each year.

2.21 "PPO" shall mean Preferred Provider Organization.

2.22 "Qualifying Life Event" means marriage, birth or legal adoption of a child, legal separation, divorce, legal guardianship, loss of other coverage, death, or marriage of a Dependent child.

2.23 "Retiree" means any former Employee of the City of Detroit who separated from active employment with the City on or before December 31, 2014, and is in receipt of retirement benefits from the Police and Fire Retirement System of the City of Detroit.

2.24 "Retirement System" means the Police and Fire Retirement System of the City of Detroit, as amended.

2.25 "Spouse" means a Retiree's lawful spouse at the time of retirement or as otherwise recognized under the Plan of Adjustment, including those spousal members recognized under the Settlement Agreement in the certified class action captioned *Weiler et al. v. City of Detroit*, Case No. 06-619737-CK (Wayne County Circuit Court), pursuant to the "Consent Judgment and Order of Dismissal" entered in that action on August 26, 2009, provided that in the case of a Surviving Spouse such marital status exists at the date of the Participant's death.

2.26 "Surviving Spouse" means the widow or widower of a Retiree, who is eligible for receipt of benefits under the Plan.

2.27 "Trust" or "RHC Trust" means the City of Detroit Police and Fire Retiree Health Care Trust, as amended.

2.28 "TPA" shall mean the Third Party Administrator retained by the Board to assist in the day to-day administration and operation of the Plan and Trust.

ARTICLE III. PARTICIPATION

3.01 Eligibility. (1) Eligibility for participation in the Plan shall be limited to Retirees (including their eligible Spouses and Dependents), who separated from active employment with the City on or before December 31, 2014, and who were eligible to receive retiree health care benefits from the City at the time of retirement.

(2) The Board may adopt such additional rules and regulations regarding eligibility for participation in the Plan, as may be amended by the Board from time to time in its sole discretion.

(3) In all cases of doubt the Board of Trustees shall determine eligibility to participate in the Plan.

3.02 Participation. (1) All Eligible Retirees shall immediately become eligible to participate in the Plan as of the Plan's Effective Date. Participants may be required to contribute to the cost of coverage under the Plan in accordance with rules and procedures adopted by the Board. Contributions toward the cost of health insurance benefits provided to Participants, if any, will be deducted from the Retiree's or Surviving Spouse's monthly pension payment. In the event that a Participant's or Surviving Spouse's monthly pension, if any, is insufficient to make the required monthly contribution, such contributions shall be made in accordance with rules and procedures adopted by the Board.

(2) An Eligible Retiree or Spouse who wishes to participate in the Plan shall complete the annual open enrollment process to participate. The annual election to participate in the Plan shall

be irrevocable unless the Participant otherwise becomes eligible to change his election(s) pursuant to Section 3.07 herein.

(3) If an eligible Retiree and his/her Spouse are each participating in one of the Plan's Medicare Advantage plans as an eligible Participant, they may each elect individual coverage, or they may elect joint coverage if circumstances allow. There will be no dual insurance coverage under the Plan.

(4) Termination of participation in the Plan shall be in accordance with all applicable state and federal laws including, but not limited to, the ACA. No less than thirty (30) days prior to the effective date of termination, the affected individual(s) shall be provided with written notice of termination of participation, including the reason for termination. Participation in the Plan shall terminate upon occurrence of the following:

(a) Death. The date the Participant dies;

(b) Cessation of Contributions. If the Participant fails to make any contribution required under the plan, coverage shall terminate in accordance with an applicable Insurance Agreement and applicable state or federal law;

(c) a Participant's voluntary election to cease coverage under the Plan;

(d) in the case of a Spouse or Dependent, as of the date the Spouse or Dependent ceases to be a Spouse or Dependent as defined in this Plan;

(e) Plan termination. The date the Plan terminates; or

(f) As otherwise provided under the terms of the Plan and in accordance with applicable law.

(5) Effective January 1, 2025, in the event a current Participant is deemed ineligible for continued coverage from the Plan by the Board or TPA, the required notice of termination shall provide the Participant with a period of ninety (90) days from the date of the notice, before coverage under the Plan is effectively terminated.

3.03 Enrollment. (1) Each eligible Retiree and Spouse shall be provided timely written notice of his or her eligibility and right to enroll in coverage under the Plan. In connection with his or her enrollment for coverage, the Participant shall furnish all pertinent information requested by the Board, Plan Administrator, and/or Insurance Carrier, including but not limited to the names, relationships and birth dates of the Participant's eligible Spouse and Dependent(s).

(2) Spouses and Dependents shall be eligible for coverage as provided herein and/or any Insurance Agreement. Eligible Spouses and Dependents shall be enrolled for coverage under the

Plan at the time the Participant enrolls for coverage under the Plan during an open enrollment period, or as provided for in subparagraph (3).

(3) Participants must report Qualifying Life Events to the Plan Administrator within thirty (30) days of the event in order to make coverage changes under the Plan. Notification beyond thirty (30) days of the Qualifying Life Event will delay the effective date of any coverage changes to the first day of the calendar month following the date on which notification was made. If failure to report a Qualifying Life Event within thirty (30) days results in additional benefit costs to the Trust due to non-termination of benefits, the Participant may be held responsible for such additional costs.

ARTICLE IV. BENEFITS

4.01 Benefits. (1) Beginning on the Effective Date, the Plan shall provide health care benefits to each eligible Participant and, if elected, to his or her eligible Dependent(s). The benefits provided under the Plan are as set forth herein or as otherwise provided in the individual plan documents and/or Insurance Agreements which are incorporated herein by reference. A complete description of the benefits provided under the Plan, inclusive of those set forth in the individual plan documents and/or Insurance Agreements, shall be maintained by the Plan Administrator.

4.02 Limitation on Benefits. Participants are not entitled to cash or any other benefit in lieu of medical coverage. The benefits provided will be limited to medical care as defined by Section 213(d) of the Code.

4.03 Continuation Coverage Under COBRA. (1) Notwithstanding any provision to the contrary, any Participant or Dependent who is eligible for continuation coverage under the Plan pursuant to COBRA shall be allowed to continue to participate in the Plan, as long as such Participant or Dependent complies with the provisions set out in COBRA.

(2) The Board shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

4.04 Women's Health and Cancer Rights Act. (1) If a Participant or Dependent had or is going to have a mastectomy, such Participant or Dependent may be entitled to certain benefits under the Women's Health and Rights Act of 1988, as amended. For individuals receiving mastectomy related benefits, coverage will be provided in a manner in consultation with the attending physician and the patient for:

(a) All stages of reconstruction of the breast(s) on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications of the mastectomy, including lymphedema.

(2) These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

4.05 Special Rights Upon Childbirth. (1) NMHPA provides that group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length stay in connection with childbirth for the mother or the newborn to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., the physician, nurse, physician assistant, or midwife (if covered) of a Participant), after consultation with the mother, discharges the mother or newborn earlier.

(2) Also, under NMHPA, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

ARTICLE V. CLAIMS AND APPEALS

5.01 Insured Benefits. (1) Claims and appeals for insured benefits (i.e., Medicare Advantage PPO & HMO coverage, prescription drugs, dental, and vision benefits) will be decided by the applicable Insurance Carrier as set forth in the applicable coverage documents. The decision of the Insurance Carrier is final and binding.

(2) The Board shall not be responsible for the interpretation and/or validity of any Insurance Agreement issued in connection with the Plan or Trust or for the failure on the part of the Insurance Carrier to make payments provided under such Insurance Agreement, or for the action of any person which may delay payment or render an Insurance Agreement null and void or unenforceable in whole or in part.

5.02 Self-Funded Benefits. (1) Claims for self-funded benefits (e.g., HRA benefits) and other special benefit claims will be decided by the Plan Administrator, the Board, or other delegate as circumstances dictate. The decisions of the Board are final and binding.

(2) The claims and appeals process shall afford a full, fair, and timely claim review.

5.03 HRA Claims Procedure. (1) All Claims for HRA benefits must be submitted to the TPA in accordance with the TPA's filing procedures.

(2) To activate the Plan's claims processing procedures, a HRA Claim must:

(a) Be written or be electronically submitted in accordance with the Electronic Data Interchange standards of the HIPAA;

(b) Be received by the TPA, or other delegate;

(c) Identify a specific claimant/patient;

(d) Provide a description and date of a specific treatment, service or product for which reimbursement is requested; and

(e) Identify the total out-of-pocket cost paid by the claimant/patient to be reimbursed.

(3) A request is not a Claim if it is:

(a) Not made in accordance with the Plan's benefit claims filing procedures;

(b) Made by someone other than the claimant or the claimant's authorized representative;

(c) Made by a person who will not identify himself or herself (anonymous);

(d) A casual inquiry about benefits such as verification of whether a service or product is covered;

(e) For pre-approval of a reimbursement request; or

(f) An eligibility inquiry that is not a request for benefits.

(4) A Participant must file a Claim for HRA benefits no later than March 31 of the calendar year following the end of the Plan Year in which the qualified medical expense was incurred. HRA claims submitted after such period shall be denied by the Plan Administrator unless the Participant can show that it was not possible to file the HRA claim within the required time and that the HRA claim was filed as soon as reasonably possible. On appeal as provided in Section 5.06 herein, the Board may take into consideration such other extenuating circumstances in granting HRA claims submitted beyond the March 31 deadline, but in no event shall HRA claims submitted more than 12 months following the end of the Plan Year in which the qualified medical expense was incurred be approved by the Board.

5.04 Claim Determinations. (1) Claims for insured benefits are administered by the applicable Insurance Carrier and notification of the Carrier's benefit determination will be communicated to a Participant in accordance with the applicable coverage documents.

(2) The TPA will notify claimants of the Plan's HRA benefit or eligibility determination within a reasonable period of time, but not later than thirty (30) days after receipt of a Claim.

(a) The initial thirty (30) day claim period may be extended for an additional fifteen (15) days due to circumstances beyond the TPA's control. If an extension is necessary, affected Participants will be notified of the circumstances necessitating the extension and the date by which a decision is expected.

(3) Participants that submit HRA Claims without sufficient information and/or documentation to verify the Claim(s) shall be notified by the TPA that they have thirty (30) calendar days to provide the necessary information and/or documentation to verify the Claim(s). Failure to provide the necessary verifying information/documentation within thirty (30) calendar days of notification will result in denial of the HRA Claim(s) by the TPA.

5.05 Adverse Benefit Determinations. (1) Notice of Adverse Benefit Determinations shall be communicated to claimants in writing and shall include:

(a) The reason(s) for the adverse determination;

(b) The Plan provisions on which the adverse determination was based;

(c) Additional information needed from the claimant, if any;

(d) An explanation of the Claims review and appeal procedures and applicable time limits;

(e) A statement regarding any internal rule, regulation, guideline, protocol, or other policy that was relied upon in making the adverse determination; and

(f) A statement that a claimant will be provided, upon request, copies of all documents, records, and other information relevant to the Claim.

5.06 Right to Appeal. (1) Adverse Benefit Determinations must be appealed in writing to the TPA within thirty (30) calendar days of notification of an Adverse Benefit Determination ("Level 1 Appeal").

(a) The Level 1 Appeal may (but is not required to) include issues, comments, documents, and other records the claimant wants considered by the TPA, on appeal. All information submitted will be taken into account on review by the TPA, even if it was not reviewed as part of the initial decision.

(b) The TPA shall notify the claimant of its determination within thirty (30) calendar days following receipt of the Level 1 Appeal. If the Level 1 Appeal is denied, the TPA shall provide the claimant with written notice of the denial, specifying:

(i) the reasons for the denial;

(ii) the Plan provisions on which the denial is based;

(iii) a statement regarding any internal rule, regulation, guideline, protocol, or other policy that was relied upon in denying the Level 1 Appeal; and

(iv) a statement explaining the Plan's Level 2 Appeal procedures.

(2) Level 1 Appeals that are denied by the TPA shall be automatically submitted to the Board of Trustees ("Level 2 Appeal") within sixty (60) calendar days of the notice of denial of the Level 1 Appeal.

(a) The Level 2 Appeal may (but is not required to) include issues, comments, documents, and other additional records the claimant wants considered by the Board, on appeal. All information submitted will be taken into account on review by the Board, even if it was not reviewed as part of the initial decision or the Level 1 Appeal. Claimants may request a hearing before the Board. The Board shall schedule any required hearing and notify the claimant of his/her hearing date within thirty (30) calendar days after receipt of the Level 2 Appeal.

(b) The Board shall notify the claimant of its Level 2 Appeal determination within thirty (30) calendar days following its receipt of the Level 2 Appeal or the conclusion of the Level 2 Appeal hearing, whichever is later. If the Level 2 Appeal is denied, the Board shall provide the claimant with written notice of the denial, specifying:

(i) the reasons for the denial;

(ii) the Plan provisions on which the denial is based;

(iii) a statement regarding any internal rule, regulation, guideline, protocol, or other policy that was relied upon in denying the Level 2 Appeal;

(iv) a statement that a claimant will be provided, upon request, copies of all documents, records, and other information relevant to the Claim for benefits; and

(v) a statement of the claimant's right to bring an action under applicable state or federal law.

(3) Subject to applicable state or federal law, any interpretation of any provision of the Plan made in good faith by the Board as to any Participant's rights or benefits under the Plan is final and shall be binding.

5.07 Payment of Claims to Others. If the Board, Insurance Carrier or TPA determines that any person to which an amount is payable under the Plan is unable to care for his or her affairs because of sickness, injury, incapacity, death, or is a minor, then any payment due (unless a prior

claim has been made by a duly appointed legal representative) may, if the Board, Insurance Carrier or TPA so elects, be paid to the individual's spouse, dependent child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator, Insurance Carrier, or TPA to be a proper recipient on behalf of such person otherwise entitled to payment. The Board, Insurance Carrier, or TPA shall not have an affirmative obligation to investigate whether a person is or is not capable of caring for his or her affairs. Any such payment shall be a complete discharge of the liability of the Plan.

5.08 Improper or False Claims. (1) If a claimant furnishes false or misleading information to the Board, the TPA, the Insurance Carrier(s), or to any of the Plan's agents, employees, or representatives, the Plan will deny all or part of the Claim and will charge the claimant for any expenses incurred on account of the false or misleading information.

(a) If benefits have already been paid on account of the false or misleading information, the Plan will be entitled to recover all benefits wrongfully provided, plus all expenses incurred in such recovery including attorney's fees, costs, and any other expenses, and/or will reduce the Participant's future benefits, if any, until the Plan has recovered the amounts owed.

(2) The Plan may terminate coverage for any act or omission by a Retiree, Spouse, or Dependent that indicates an intent to defraud the Plan. Grounds for termination include the submission of any Claim and/or statement containing any materially false information, any information that conceals for the purpose of misleading, and/or any act that could constitute a fraudulent insurance act.

ARTICLE VI. ADMINISTRATION

6.01 Plan Administration. The Plan Administrator shall have the authority and responsibility for the administration of the Plan. In addition to any rights, duties, or powers specified under the Plan, the Plan Administrator shall have the following rights, duties, and powers:

(a) Procedure. Adopt and apply rules and procedures to ensure the orderly and efficient administration of the Plan;

(b) Information. Obtain from or transmit to, the Board, Participants, and any other necessary party, all information necessary for the proper administration of the Plan;

(c) Disclosure and Reporting. Make all disclosures to Participants and file all governmental reports, as required by law;

(d) Specialists or Advisors. In consultation with the Board, retain the services of such persons or entities as it may deem necessary for the proper administration of the Plan. The

Plan Administrator may utilize, among others, actuaries, accountants, consultants, third party administrators, legal counsel, or any other specialist or advisor.

(e) All Other Necessary and Proper Functions. Perform any other necessary or proper functions in the operation of the Plan.

6.02 Allowable Mid-Year Changes. (1) No Participant in the Plan will be allowed to alter or discontinue the Participant's annual elections during a Plan Year except when due to a Qualifying Life Event.

(2) The Plan Administrator shall be notified as soon as reasonably possible in the event of a Qualifying Life Event. The Plan Administrator may require additional documentation as evidence of the Qualifying Life Event, and completion of appropriate forms and documentation by the relevant parties.

6.03 Exclusive Benefit. The Plan shall be administered solely for the benefit of the Participants, and for the exclusive purpose of providing Participants with the benefits stated herein.

ARTICLE VII. AMENDMENT AND TERMINATION

7.01 Amendment. (1) The provisions of this Plan may be amended at any time or from time to time by resolution of the Board of Trustees, and the provisions of any such amendment may be made applicable to the Plan as constituted at the time of the amendment, provided that this Plan shall not be amended in any manner which causes or allows any portion of the Trust allocable to the Plan to be used for purposes other than providing health care benefits to eligible Retirees and their eligible Spouse and/or Dependents.

(2) The Board may also remove or change Insurance Carriers, other benefits providers, administrators, or other service providers at any time provided that such changes would not result in the violation of any applicable laws.

7.02 Limitations. No amendment shall adversely affect the benefits of a Participant or beneficiary under the Plan on a retroactive basis, unless otherwise necessary to bring the Plan into compliance with applicable laws and regulations.

7.03 Termination of the Plan. The Board may, by resolution, terminate the Plan at any time, provided that this Plan shall nevertheless continue in effect until such time as may be necessary to carry out the provisions of the Plan and for a period of time sufficient to wind up the affairs of the Trust.

ARTICLE VIII. MISCELLANEOUS

8.01 No Assignment. The Plan shall not recognize any assignment, alienation, attachment, garnishment, legal process, sale, transfer, pledge, encumbrance of or charge upon any benefits

payable under the Plan, and any attempt to encumber, alienate or assign any benefit payable under the Plan shall be void.

8.02 Creditors. (1) The right of a Participant to receive a benefit under the Plan shall not be subject to the claims of creditors, and shall be exempt from execution, attachment, prior assignment or any other judicial relief or order for the benefit of creditors or other third party.

8.03 Evidence. Each Participant shall cooperate with the Board or Plan Administrator by furnishing such documents, evidence, or information as the Board, insurance carrier, or third party administrator may deem necessary, and by taking such other relevant actions as may be required by the Board, insurance carrier, or third party administrator in implementing the Plan. The Board shall have no obligation under the Plan in the event of a Participant's failure to cooperate.

8.04 Withholding Taxes. To the extent required by applicable law, the Board may withhold from payments made pursuant to the Plan all federal, state, local, or other taxes as shall be required with respect to any amounts paid or payable under the Plan.

8.05 Correction of Errors. No person is entitled to any benefit under the Plan except to the extent expressly provided herein or as otherwise provided under an incorporated plan document or Insurance Agreement. The fact that the Plan made payment(s) in connection with a claim for benefits under the Plan does not establish the validity of the claim, a right to such benefits or a right to the continuation of benefits. Therefore, if a person is paid a benefit under the Plan and the Board, insurance company, or third party administrator determine that such benefit should not have been paid (whether or not attributable to an error by such person, the Board, insurance company, or third party administrator, or any other person), then such action may be taken as necessary or appropriate to remedy the situation, including, but not limited to, the deduction of the amount from any succeeding payments to or on behalf of such person under the Plan or from any amounts due or owing to such person under any other plan, program or arrangement of the Plan that benefits such person. If the Board, insurance company, or third party administrator determines that an underpayment of benefits has been made under the Plan, such action may be taken as necessary or appropriate to remedy the situation, but in no event shall interest or a penalty be paid on the amount of underpayment.

8.06 Notice to Participants. Each Participant shall be responsible for informing the Board of his or her correct mailing address. Any communication, statement or notice addressed and sent via prepaid first class mail to a Participant at his or her last post office address as shown on the Board's records shall be deemed to satisfy the notice requirements under the Plan.

8.07 Construction. All terms expressed herein shall be deemed to include the feminine and neuter genders and all references to the plural shall be deemed to include the singular and vice versa, all as proper construction shall dictate.

8.08 Headings and Captions. The headings and captions herein are inserted for convenience of reference only and shall not affect the meaning or interpretation of the Plan.

8.09 Severability. If any provision of this Plan is held invalid or unenforceable, such invalidity shall not affect any other provision, and the Plan shall be construed and enforced as if such provision were omitted.

8.10 Governing Law. The Plan shall be governed and construed in accordance with the laws of the State of Michigan to the extent not preempted by federal law.

ADDENDUM A

Eligibility Rules and Regulations

1. Medicare Advantage Program

A. General

1. The Trust will sponsor one or more fully insured Medicare Advantage plans through licensed and independent insurance provider(s). The Trust's Medicare Advantage plan(s) shall include coverage for prescription drugs under Medicare Part D ("MA-PD Plan").

2. The Trust may sponsor HMO and/or PPO MA-PD Plans with one or more insurance provider(s) as determined by the Board.

B. Eligibility

1. Retirees and Spouses shall be eligible to participate in the Trust's Medicare Advantage Program for so long as the Retiree or eligible Spouse meets the following conditions:

   a. Eligible for Medicare;

   b. Enrolled in both Medicare Part A and Medicare Part B;

   c. live within a MA-PD Plan(s) service area; and

   d. do not have End-Stage Renal Disease (ESRD) such that participation in a Medicare Advantage plan is prohibited pursuant to CMS rules and regulations.

2. If an eligible Retiree elects to opt-out of participation in the Trust's Medicare Advantage Program his or her Spouse may elect to individually participate in the MA-PD plan(s) sponsored by the Trust.

2. Health Reimbursement Arrangement (HRA)

A. General

1. The Trust will sponsor a HRA for non-Medicare eligible Retirees and Spouses as detailed below.

2. The Trust will also offer a HRA benefit to Medicare eligible Retirees and Spouses electing to opt-out of coverage under the Trust's Medicare Advantage plans.

B. Eligibility

1. Medicare Eligible Opt-Out HRA

a. Medicare eligible Retirees and Spouses electing to opt-out from coverage under the Trust's Medicare Advantage plans shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

2. Non-Medicare Eligible HRA

a. Non-Medicare eligible Retirees and Spouses shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

b. Participants with a total household income of $75,000.00 or less and purchasing health insurance through a policy purchased on a public exchange may be eligible to receive an increased monthly HRA benefit.

i. Participants claiming eligibility for this increased HRA benefit will be required to provide verification of coverage under a health insurance policy purchased through a public exchange, along with a copy of his or her most recently filed tax return as proof of a total household income of $75,000.00 or less.

3. Over 65 Non-Medicare Eligible HRA

a. Retirees and Spouses over the age of 65 who are not eligible directly, or through his or her spouse, for free coverage under Medicare Part A on account of his or her status as Medicare exempt during employment with the City shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

b. Retirees and Spouses claiming eligibility for this HRA benefit will be required to provide proof of ineligibility for free Medicare Part A coverage through submission of appropriate documentation to the Board.

4. Duty Disabled HRA

a. Non-Medicare eligible Retirees in receipt of a duty disability pension from the Police and Fire Retirement System of the City of Detroit ("PFRS") shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

b. Retirees claiming eligibility for this HRA benefit may be required to submit proof of duty disabled status through submission of appropriate documentation to the Board.

c. Upon attaining Medicare eligibility, or conversion from duty disability status to a regular service retirement, Participants and Surviving Spouses shall be ineligible to receive the Plan's Duty Disability HRA benefit.

5. Spousal HRA

    a. Spouses under the age of 65 who are not eligible to be enrolled under the Trust's Medicare Advantage plans shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit.

C. Limitations

1. Amounts

    a. Monthly HRA benefits shall not exceed $400 per member, per month, unless otherwise authorized by the Board in its sole discretion.

2. Rollover

    a. HRA benefits that remain unused at the end of any Plan Year (including any applicable grace period) shall be deemed forfeited and will not carry over into the subsequent Plan Year.