Coalition of Detroit Public Safety Unions Trust
City of Detroit Retired Police and Fire Employees
Health Reimbursement Arrangement (HRA) Plan

Effective April 1, 2017

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ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

The Board of Trustees of the Coalition of Detroit Public Safety Unions Trust Fund (CDPSU) hereby establishes the CDPSU Trust City of Detroit Retired Police and Fire Employees Health Reimbursement Arrangement (HRA) Plan (the "Plan") effective April 1, 2017 (the "Effective Date"). The Plan is designed to permit eligible retired City of Detroit Police and Fire Fighter Employees to obtain reimbursement of covered out-of-pocket expenses on a non-taxable basis.

1.2 Legal Status

This Plan is a medical reimbursement plan under Code §§ 105 and 106 and regulations issued thereunder and as a health reimbursement arrangement as defined under Internal Revenue Service (IRS) Notice 2002-45 and shall be interpreted to accomplish that purpose. The Plan is also designed to be a "stand-alone" retiree-only HRA within the meaning of IRS Notice 2013-54 with a "spend-down" feature. Eligible retirees (and their surviving spouses) generally can "spend-down" remaining HRA allocations on eligible Medical/Dental/Prescription insurance premium Expenses until their allocations are exhausted. Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from the gross income of Participants and Beneficiaries under Code § 105(b).

ARTICLE II. DEFINITIONS

2.1 Definitions

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in this Article II.

(a) **"Administrator" or "Plan Administrator"** means the Board of Trustees of CDPSU or such person or person to whom such responsibility is delegated by the Board of Trustees of CDPSU.

(b) **"ACA"** means the Patient Protection and Affordable Care Act of 2010, as amended.

(c) **"Beneficiary"** as used herein shall mean a Spouse or child under age 26 designated by a Participant, or by the terms of the Plan, who is or may become entitled to a benefit thereunder.

(d) **"Benefits"** means the reimbursement benefits for Medical Care Expenses described under Article V.

(e) **"Board of Trustees" or "Trustees"** means the Board of Trustees of the CDPSU Trust Fund.

(f) **"City"** means the City of Detroit.

(g) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(h) **"Code"** means the Internal Revenue Code of 1986, as amended from time to time, and the regulations promulgated thereunder.

(i) **"Compensation"** means the wages or salary paid to an eligible City Police Officer or Fire Fighter by the City of Detroit.

(j) **"Collective Bargaining Agreement" or "CBA"** means an agreement or agreements between an employer and a participating Union (or its locals) requiring Contributions to the Fund.

(k) **"Contributions"** as used herein shall mean the money paid or payable into the Fund by an Employer pursuant to a Collective Bargaining Agreement, pursuant to a Participation Agreement, or other payments made for the benefit of Fund Participants and related to their current or former employment.

(l) **"Dependent"** means any individual who is covered as a Beneficiary under the HRA Plan and who is a tax dependent of the Participant as defined in Code §152, with the following exception: any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO or National Medical Support Order, even if the child does not meet the definition of "Dependent."

(m) **"Effective Date"** of this Plan has the meaning described in Section 1.1.

(n) **"Employee" or "Employees"** as used herein shall mean:

- any person covered by a Collective Bargaining Agreement or a Participation Agreement with the City of Detroit that has been approved or accepted by the Board of Trustees, and who is engaged in employment with respect to which the Employer is obligated to make Contributions to the Trust Fund; and

- a former employee who is entitled to receive retiree health care benefits pursuant to one or more Collective Bargaining Agreements.

(o) **"Employer" or "Employers"** means the City of Detroit to the extent that it has signed a Collective Bargaining Agreement, Participation Agreement or has signed or is subject to other proper evidence of employment terms obligating it to make Contributions to the Trust Fund and be bound by this Agreement and actions by the Board and that has been approved or accepted by the Board of Trustees.

(p) **"Eligible Employee"** means an Employee for whom Contributions are made by the Employer or other persons on behalf of or for the benefit of the Employer. An Eligible Employee shall only participate in this Plan, as provided in Section 3.1.

(q) **"Enrollment Form"** means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

(r) **"FMLA"** means the Family and Medical Leave Act of 1993, as amended.

(s) **"Health FSA"** means a health flexible spending arrangement as defined in Prop. Treas. Reg. § 1.125-5.

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

(u) **"HRA"** means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

(v) **"HRA Account"** means the notational HRA Account described in Section 5.3 and created and maintained by a third-party administrator selected by the Board of Trustees.

(w) **"Medical Care Expenses"** has the meaning defined in Section 5.2.

(x) **"Open Enrollment Period"** with respect to a Plan Year means the month of November in the year preceding the Plan Year, or such other period as may be prescribed by the Trustees.

(y) **"Participant"** means a person who is an Eligible Employee and who is participating in this HRA Plan in accordance with the provisions of Article III.

(z) **"Participation Agreement"** means a written agreement between the City, another contributing person or entity and the Fund setting forth the terms and conditions for making contributions into the Fund.

(aa) **"Period of Coverage"** means the Plan Year during which a Participant is an Eligible Employee, with the following exceptions:

- for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and

- for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.3.

A different Period of Coverage (*e.g.*, monthly) may be established by the Administrator and communicated to Participants.

(bb) **"Plan"** means the CDPSU Trust City of Detroit Retired Police and Fire Employees Health Reimbursement Arrangement (HRA) Plan as set forth herein and as amended from time to time.

(cc) **"Plan Year"** means the calendar year (*i.e.*, the 12-month period commencing January 1 and ending on December 31).

(dd) **"Public Health Services Act"** means the Public Health Services Act of 1944, as amended.

(ee) **"QMCSO"** means a qualified medical child support order, as defined in ERISA § 609(a).

(ff) **"Retire", "Retired", or "Retirement"** means termination of employment with the City of Detroit, meeting the CBA terms for retirement, or upon the effective date of a Social Security Disability award.

(gg) **"Spouse"** means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

(hh) **"SPD"** means any separate summary plan description describing the terms of this Plan.

(ii) **"Trust Fund" or "Fund"** means the Trust Fund established and known as the Coalition of Detroit Public Safety Unions Trust Fund.

(jj) **"Union" or "Unions"** means the Detroit Police Officers' Association, the Detroit Police Sergeants and Lieutenants Association, the Detroit Police Command Officers Association and/or the Detroit Fire Fighters' Association, individually or collectively, as referenced herein. "Union" also shall mean any successors to such organization or organizations.

(kk) **"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended and, where applicable, also shall include the Heroes Earnings Assistance and Relief Tax Act of 2008, as amended.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Initial Eligibility and Coverage

An Employee is eligible to participate in the HRA Plan if the Employee is/was covered by a Collective Bargaining Agreement or Participation Agreement or other evidence of employment rights that requires or required contributions to the HRA Plan on behalf of that Employee and the Employee satisfies the following additional criteria:

(a) Retirement from employment with the City, provided that the Employee has satisfied his/her CBA requirements for retirement; or

(b) Separation from employment with the City after ten (10) years of employment but prior to retirement.

If an Employee is eligible for Medicare, the Employee is not eligible to participate in the Plan.

Upon becoming a Participant, the HRA Plan will create a notational HRA account for the Participant's benefit. This notational HRA Account, as provided in Section 5.3, will be available for permitted benefits as determined by the Board of Trustees from time to time. The pertinent terms of eligibility and benefits generally will be set forth herein, but may be set forth in appendices to this Plan Document. Collective Bargaining Agreements setting forth such terms will only affect HRA Plan benefits to the extent that such terms are: 1) expressly adopted by the Trustees; and 2) incorporated as an exhibit to this HRA Plan or incorporated by reference. The pertinent provisions contained in those documents only may be deemed to be incorporated into this HRA Plan and only with respect to the employees subject to such Agreements. To the extent that the provisions of a Collective Bargaining Agreement or Participation Agreement may conflict with the provisions of this Plan, the Plan shall prevail.

3.2 Enrollment When First Eligible

Eligible Employees will become Participants and will commence participation in this Plan on the first day of the month after the eligibility requirements have been satisfied, provided that any required enrollment forms have been submitted to the Plan Administrator. Once enrolled, the Employee's participation will continue from month-to month and year-to-year until the Employee's participation ceases pursuant to Section 3.3.

The Enrollment Form shall identify the Spouse and Dependent(s), if any, whose Medical Care Expenses may be submitted to this HRA Plan and include such other information as determined by the Board of Trustees in their sole discretion.

3.3 Termination of Participation

A Participant will cease to be eligible to participate in this Plan upon the earlier of:

(a) Termination of this Plan; or

(b) The Trustees of the CDPSU Trust Fund determine, in their exclusive discretion, that the contributions provided pursuant to the Collective Bargaining Agreement or otherwise are insufficient to pay benefit claims presented; or

(c) Exhaustion of credit available under the Participants' notational HRA Plan Account; or

(d) Voluntary waiver or "opt-out" of HRA Plan benefit eligibility or coverage;

(e) Forfeiture of the Participant's notational HRA Account in accordance with Section 3.8; or

(f) Attainment of age 65 or otherwise becomes eligible for Medicare.

Upon termination of participation, the Participant's coverage ceases. There will be no cash-out, reimbursements or debits from any remaining balance in that Participant's HRA Account for proper medical care expenses submitted for reimbursement following the Participant's loss of eligibility in this HRA Plan.

Any unclaimed HRA benefit payments (*e.g.*, uncashed reimbursement checks) that remain 12 months after the Period of Coverage in which the Medical Care Expense was incurred will be forfeited.

Reimbursements from the notational HRA Account after termination of participation will be made pursuant to Section 5.6.

3.4 Death of a Participant

Upon the death of a Participant, no additional contributions will be made to the Participant's account. The surviving Spouse of the Participant shall continue to be entitled to reimbursements for permitted Medical Care Expenses until such time as the Participant's HRA Account reaches a zero balance or otherwise becomes ineligible for such reimbursement.

Other Dependents of the deceased Participant covered under the Plan may continue participation in the Plan until they no longer meet the definition of "Dependent" or the HRA account reaches a zero balance.

Any unused stipend attributable to a deceased Employee that is not paid or eligible for payment in accordance with this Section will be forfeited and neither such Employee, Spouse or any other person will have any right to any benefit or payment with respect to such assets. All such amounts remaining in such case shall revert to the Plan and shall be used for such proper purposes as the Trustees

determine in their sole discretion. In no event shall the remaining assets be paid in cash to any person or revert to the Employer.

3.5 Death of an Employee before Becoming a Participant

If the Employee's death occurs before Retirement, the surviving Spouse (or Dependents) of the Employee will not be entitled to a Benefit.

3.6 Opt-Outs

A Participant, an Employee and/or the Spouse of a Participant may opt-out of HRA Plan participation, coverage and/or benefit eligibility. An opt-out election shall be made pursuant to reasonable procedures determined by the Board of Trustees. An opt-out election will be effective as of the date properly determined by the Board of Trustees in its reasonable discretion consistent with requirements, if any, imposed by applicable law, including the ACA and the Code. Opt-out elections shall be irrevocable. If an Employee or Participant and/or Spouse and/or Dependent are living, an opt-out election by such Participant or Employee also shall be binding and be effective for such person's Spouse and/or Dependent.

3.7 Continuation Period

A Continuation Period is a period when a Participant or Spouse of a deceased Participant, who reaches age 65 or otherwise becomes eligible for Medicare, may continue to submit claims for covered HRA Account reimbursement. The Continuation Period lasts for three years following such cessation of participation. At the completion of the Continuation Period, the remaining notational HRA Account balance of the Participant, Spouse, as applicable, shall be forfeited pursuant to Section 3.8.

3.8 Forfeiture

A Participant's notational HRA Account is forfeited when any of the following events occur:

(a) Death of a Participant and the Spouse/Dependent (if any) prior to exhaustion of the Participant's notational HRA Account or expiration of the applicable Continuation Period, if any;

(b) Death of an Employee prior to becoming eligible for HRA Plan Benefits;

(c) An Employee, Participant, or the Spouse/Dependent of a Participant, opts-out of HRA Plan Benefits or participation pursuant to Section 3.6;

(d) The Board of Trustees, at its proper sole discretion, reduces or eliminates notational HRA Account balances, eliminates or modifies HRA Plan eligibility and/or modifies or terminates this HRA Plan or, if applicable, any of the provisions of this HRA Plan; or

(e) Return to City employment after becoming a Participant, provided that a Participant who returns to City employment after becoming a Participant may have his forfeited notational HRA Account restored as determined by the Board of Trustees.

ARTICLE IV. BENEFITS OFFERED AND METHOD OF FUNDING

4.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Article III, a notational HRA Account will be established. The amount of benefits payable to any Participant, and/or Spouse and/or Dependent, shall never exceed notational amounts assigned to that notational HRA Account by the Board of Trustees consistent with procedures established by the Trustees and in their proper discretion. All HRA Plan Benefits shall be payable to Participants, Spouses and/or Dependents only based on such notational HRA Accounts. No Participant, Spouse and/or Dependent will have any interest in Fund assets other than through benefits properly payable based on such notational HRA Accounts.

Benefits are payable only when a Participant, eligible Spouse and/or Dependent:

(a) Has satisfied the eligibility criteria of Section 3.1, has an unused notational HRA account balance;

(b) Has not become eligible for Medicare, subject to the provisions of Section 3.7;

(c) Has not opted-out of HRA Benefits pursuant to Section 3.6; and

(d) In the case of persons eligible for Benefits pursuant to Section 3.7, has not forfeited the account due to inactivity.

In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

4.2 Employer Contributions to the Plan

The following describes the types of permissible and impermissible contributions to the Plan.

(a) **Employer Contributions.** Employer contributions made pursuant to an applicable Collective Bargaining Agreement or other agreement and any investment earnings allocated to such sums by the Board of Trustees in its sole proper discretion are the only source of assets from which to pay HRA Plan Benefits paid with reference to the notational HRA Accounts created hereunder.

(b) **Participant Contributions.**

There are no Participant contributions for Benefits under the Plan.

(c) **Other Contributions.**

The HRA Plan may accept contributions from persons other than the Employer to the extent provided by the City's Plan of Adjustment (as defined in the Collective Bargaining Agreements) or otherwise.

(d) **No Funding Under Cafeteria Plan.**

Under no circumstances will the Benefits be funded with salary reduction contributions, employee contributions (*e.g.*, flex credits) or otherwise under a cafeteria plan.

4.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Fund. Nothing herein shall be construed to require the Fund to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Fund from which any payment under this Plan may be made. The Fund, in no event has any obligation to fund the HRA Plan or its notational accounts beyond the amounts attributable to Employer Contributions adjusted, at the proper discretion of the Board of Trustees for earnings or losses and administrative expenses.

Notwithstanding the foregoing, amounts set aside to fund HRA Plan Benefits may be invested or made available for covered HRA Plan Benefit payments through the purchase of insurance contracts. Such contracts may provide for the direct reimbursement of proper covered expenses consistent with the terms of this HRA Plan and rules governing HRAs.

4.4 Employer Contributions

Employer Contributions made by Employers to the Plan will be determined in accordance with the terms of the pertinent Collective Bargaining Agreement or Participation Agreement and will be used to fund the HRA Account of the Participants who are eligible to receive an allocation of contributions based on the terms of this HRA Plan but consistent with applicable Collective Bargaining Agreements or other agreements, as accepted by the Trust Fund.

4.5 Income

Allocation of net income will be subject to the proper discretion of the Board of Trustees. Such allocation, as determined by the Trustees, may take into account all relevant factors including, without limitation, proceeds of contributions, and IBNR (Incurred But Not Reported) reserves, as applicable and reasonably determined by the Trustees. For these purposes "Net Income" shall include earnings on investments (realized and unrealized) reduced by losses (realized and unrealized), Investment Expenses and Administrative Expenses, during the applicable Valuation Period. "Administrative Expenses" shall include all items of administration costs and charges as well as any applicable taxes paid during the applicable Valuation Period. "Investment Expenses" shall include all items of investment expense paid or losses experienced during the applicable Valuation Period. The "Valuation Date" shall be December 31 of each Plan Year or such more frequent Valuation Dates as the Trustees may decide upon.

ARTICLE V. HEALTH REIMBURSEMENT BENEFITS

5.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's notational HRA Account as determined by the Trustees from time to time.

5.2 Eligible Medical Care Expenses

Under the notational HRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage when benefits are payable as described in Section 4.1.

(a) **Incurred.** A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the Participant was a Participant in the Plan during both Periods of Coverage.

(b) **Medical Care Expenses Generally.** The Board of Trustees has determined that, for purposes of this HRA Plan, reimbursable Medical Care Expenses will be limited to only health insurance premiums, including medical, dental and vision premiums, but not long-term care premiums, incurred by or on behalf of a Participant and/or the Participant's Spouse and/or Dependents.

Notwithstanding the foregoing, "Medical Care Expenses" generally means expenses incurred by a Participant, his/her Spouse and/or Dependents for medical care, as defined in Code Section 105 and Section 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection 105(c). Medical Care Expenses shall include premiums for group health insurance covering medical care (including amounts paid as premiums under Part B, C or D of Title XVIII of the Social Security Act) including COBRA premiums, or for any qualified long term care insurance contract as defined in Code Section 7702B(b). Medical Care Expense shall not include over-the-counter (OTC) medicines, drugs or insulin unless such medicines are prescribed by a physician and meet the Plan's requirement for documenting such prescription.

Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse and/or Dependents shall be charged against the Participant's HRA Account.

(c) **Medical Care Expenses Exclusions.** "Medical Care Expenses", defined generally, shall not include the expenses listed as exclusions under Appendix A to this Plan.

(d) **Cannot Be Reimbursed or Reimbursable from Another Source.** Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through another health insurance plan, other insurance, or any other accident or health plan (but see Section 5.8 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere (*e.g.*, because another health insurance plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article V.

5.3 Establishment of Account

The Trustees will establish and maintain a notational HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The notational HRA Account so established may be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts or a similar insurance contract-based arrangement as determined by the Trustees.

(a) **Crediting of Accounts.** A Participant's notational HRA Account will be credited with additional amounts at the time determined by the Trustees, in the Trustees' proper discretion.

(b) **Debiting of Accounts.** A Participant's notational HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage. The Board of Trustees may, but shall not be required to, debit the account for administrative expenses offset by allocation of investment earnings and of forfeited accounts as determined by the Trustees in their sole discretion.

(c) **Available Amount.** The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's notational HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b). The amount available may also be reduced at any time by the Board of Trustees in its sole, reasonable discretion.

5.4 Carryover of Accounts.

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical Care Expenses submitted for reimbursement during a subsequent Period of Coverage, but only as permitted and to the extent determined by the Board of Trustees in their sole discretion. In all circumstances, upon termination of Participation under Section 3.3, the Participant's coverage ceases, and expenses submitted for reimbursement after such time will not be reimbursed, subject to the provisions of Section 5.9. In addition, any HRA benefit payments that are unclaimed (*e.g.*, uncashed benefit checks) within the 12 month period following the close of the Period of Coverage in which the Medical Care Expense was incurred shall remain the property of the Fund.

5.5 Reimbursement Procedure

(a) **Claim Submission.** Requests for reimbursement must be submitted to the Plan Administrator at least every six months and in all events within one year of the date that the claim was incurred. Receipts must total at least $50 in reimbursement requests for each individual before the claim can be considered submitted. Only one submission may be made per quarter; however, that submission may request reimbursement for multiple claims.

In lieu of after-the-fact reimbursement of permitted claims, the Board of Trustees may provide eligible Participants with monthly stipends for permitted reimbursement, subject to the Participant subsequently submitting reimbursement claim information establishing that such stipend was used for permissible reimbursements as required by the Board of Trustees and/or applicable law. The Board of Trustees may establish uniform stipends of different values for each separate participant group taking into account Employer contributions made with respect to each such participant group. Use of any such monthly stipend for reimbursement shall be subject to the same, additional reimbursement restrictions applicable to HRA debit card reimbursement arrangements.

(b) **Timing.** If applicable, within 60 days or such other reasonable time determined by the Board of Trustees, after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Fund will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan

Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied (see Section 6.1 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 30 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim. If the Participant fails to respond within the 45 day period, the claim will be denied.

(c) **Claims Substantiation.** A Participant who seeks Benefits (or who uses a notational HRA Account stipend to reimburse covered Benefits) may apply for reimbursement by submitting an application in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, setting forth:

- the person or persons on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Medical Care Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Expenses has been exhausted. To the extent permitted, any request for reimbursement of over-the-counter (OTC) medicines, drugs and insulin shall require a doctor's prescription or proof thereof satisfactory to the Board of Trustees.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $50 per individual.

(d) **Claims Denied.** No HRA or other reimbursement arrangement that permits/provides reimbursement through debit cards shall permit such debit

cards to be used to purchase OTC drugs or medicines. Covered Participants instead may purchase OTC drugs and medicines with their own money and request reimbursement by submitting receipts and copies of the applicable prescription to the Plan Administrator under procedures adopted by the Board of Trustees. Under no circumstances may such reimbursement be provided without presentation of a valid prescription for each OTC drug or medicine for which reimbursement is claimed. For reimbursement claims that are denied, see the appeals procedure in Article VI.

5.6 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 3.3, the Participant will not be able to receive reimbursements for Medical Care Expenses after his or her participation terminates. Unused amounts in the Participant's notational HRA Account will be forfeited.

Notwithstanding any provision to the contrary in this Plan and to the extent applicable to the Fund, the Participant, Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Plan Account because of a COBRA (including the Public Health Services Act) Qualifying Event, shall be given the opportunity to continue the same coverage that he or she had under the HRA Plan the day before the Qualifying Event for the periods prescribed by COBRA (including Public Health Services Act), but subject to all conditions and limitations under COBRA (including the Public Health Services Act).

5.7 Named Fiduciary; Compliance With Applicable Law.

(a) Named Fiduciary. The Board of Trustees is the Named Fiduciary for the Plan for purposes of applicable law.

(b) Laws Applicable to Group Health Plans. Benefits shall be provided in compliance with the Internal Revenue Code of 1986, Public Health Services Act, COBRA, HIPAA, FMLA, USERRA, all as they have been and may be from time to time amended, and other group health plan laws to the extent required by such laws.

5.8 Coordination of Benefits; Health FSA to Reimburse First

Benefits under this Plan are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from

another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan is not available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

5.9 Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The following provisions shall apply to the extent applicable. For purposes of this HRA Plan, COBRA shall include the applicable portions of the Public Health Services Act.

Notice and Election

COBRA coverage shall be deemed to be elected automatically by a Participant or his/her Dependent upon the occurrence of a Qualifying Event.

Qualifying Events

If any of the following Qualifying Events result in a loss of Plan coverage or eligibility to receive benefits, coverage under the Plan will continue pursuant to COBRA.

Qualifying Events are:

(a) termination of Employment prior to retirement (for reasons other than gross misconduct) or retirement;

(b) reduction in a Participant's hours of Employment to fewer than the number required for participation in the Plan;

(c) start of military service if you perform military duty for more than 30 days.

(d) entitlement to Medicare;

(e) death;

(f) divorce or legal separation; and

(g) loss of status as a Dependent.

It is generally the responsibility of the Employer to advise the Plan that a Qualifying Event has occurred. Notwithstanding the foregoing, a Participant may notify the Board of Trustees of the existence of a Qualifying Event. Absent other proper notice by the Employer or the Participant, the Qualifying Event shall be deemed to be the date on which the contribution expected to be made on behalf of the Participant was due but not received.

Details of Continuation Coverage

Coverage provided under the Plan to Participants, Spouses, and Dependents electing COBRA is the same as the coverage provided to similarly situated Participants, Spouses or Dependents who have not elected COBRA, regardless of account balances. If the coverage provided under the Plan is modified after a COBRA election is made, coverage for Participants, Spouses and Dependents who elected COBRA also will be modified.

Upon the occurrence of a Qualifying Event, a Participant, Spouse or Dependent is granted a Continuation Period of three years from the date of the Qualifying Event. In no event will the occurrence of multiple Qualifying Events create a Continuation Period of more than three years total from the date of the initial Qualifying Event.

HRA Plan Participants may spend-down any available portion of his/her notational HRA Account during the applicable COBRA Continuation Period until it reaches zero or is eliminated by proper action by the Board of Trustees, but subject to the forfeiture provisions of Section 3.8.

A Participant in an HRA Plan shall continue to be a Participant until the expiration of the Continuation Period. Participation may continue throughout the Continuation Period subject to elimination of the Participant's notational HRA Account balance by proper action of the Board of Trustees or such time such notational HRA Account is forfeited pursuant to the forfeiture provisions of Section 3.8.

An HRA Plan Participant may, but is not required to, pay the monthly COBRA premium to the HRA Account during the three year period following the occurrence of the Qualifying Event in the form of a COBRA premium if he/she wishes to increase the amount in the Participant's notational HRA Plan account. A Participant, Spouse or Dependent who wishes to make COBRA premium payments must inform the Administrator of his intention to do so.

Dependent COBRA

If the Qualifying Event is the death of the Participant, loss of status as a Dependent, divorce or separation, the Spouse or Dependent will be eligible for a Continuation Period, subject to the limitation that in no event will the occurrence of multiple Qualifying Events create a Continuation Period of more than three years total from the date of the initial Qualifying Event. This Continuation Period will run concurrently with any extension of coverage provided under Section 3.4.

If the Qualifying Event is loss of status as a Dependent, divorce or separation, the Spouse or Dependent may also immediately fund a separate account using post-tax dollars in an amount equal to the value of the Participant's account on the date of the COBRA Qualifying Event, and/or pay the monthly COBRA premium for a period of up to three years from the date of the Qualifying Event. In no event will a Spouse or Dependent be entitled to make claims or receive reimbursements other than as allowed for the Participant if the Qualifying Event had not occurred.

Additions to HRA Account During Continuation Period (COBRA Premiums)

The monthly COBRA Premium shall be 102% of the contribution required by an Employer (calculated as though made on a monthly basis) on behalf of a covered Eligible Employee. Payment is due no later than the first day of the month in which COBRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA coverage must include payment for the period of time dating back to the date that coverage terminated. If the full payment is not paid by each due date (or within the thirty day grace period for payments other than the initial payment) no further payments of premiums may be made.

Spouses or Dependents electing to make Monthly COBRA Premium payments shall have an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. Thereafter, there shall be a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, no further payments shall be allowed.

Once a timely election of COBRA coverage has been made, it is the responsibility of the Spouse or Dependent seeking COBRA coverage to make timely payment of all payments. The Fund will NOT send notice that a payment is due or that it is late, or that COBRA coverage is about to be or has been terminated due to the untimely payment of a required payment.

ARTICLE VI. APPEALS PROCEDURE

6.1 Procedure If Benefits Are Denied Under This Plan

If a claim for Medical Care benefits is denied or partially denied, or if the Trustees require additional time due to special circumstances to reach a decision, the Participant will be notified by the Plan Administrator within 90 days of receipt of the written claim form on which the claim is based. The written denial will state:

(a) the specific reasons;

(b) a reference to the specific Plan provision(s) on which the denial is based;

(c) a description of any additional material or information necessary to correct the claim;

(d) the reason why such material or information is needed; and

(e) an explanation of the Plan's claim review procedures.

If Medical Care benefits are denied, in whole or in part; and the Participant disagrees with a Fund policy, determination, or action in whole or in part, the Participant can file a written appeal to the Board of Trustees within 180 days of the date shown on the notice of denial.

The Trustees or a designated committee of the Trustees will review the appeal at their next regularly scheduled meeting immediately following the receipt of the appeal unless the appeal was received within 30 days of the date of the meeting. In this case, the appeal will be reviewed at the second meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the Trustees or the committee, the Participant will be notified in writing.

The Participant will receive written notice of the decision of the Trustees or committee promptly following the review. The notice will explain the reason for the decision and will include references to Plan provisions on which the decision is based. Any decision on an appeal by the Trustees or its designated agent shall be final and binding on all parties. No action may be filed against the Plan or Trustees or any other entity to whom administrative or claims processing functions have been delegated until the Participant first follows the claim procedures and all administrative appeals have been exhausted and there has been a final determination from the Trustees.

In connection with an appeal or renewed appeal, the Participant may review documents by making arrangements with the Board of Trustees or the Participant may request that documents be directly provided. The Fund may charge a reasonable amount to provide copies of documents.

ARTICLE VII. HIPAA PRIVACY AND SECURITY

7.1 Use and Disclosure of Protected Health Information (PHI)

Use and disclosure of PHI. The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Privacy and Security regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage, and cost sharing amounts (*e.g.*, cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);

(b) Coordination of benefits;

(c) Adjudication of health benefit claims (including appeals and other payment disputes);

(f) Subrogation of health benefit claims;

(g) Establishing employee contributions;

(h) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(i) Billing, collection activities and related health care data processing;

(j) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(k) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(l) Medical necessity reviews, or reviews of appropriateness of care or justification of charges;

(m) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(n) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health plan); and

(o) Reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

(a) Quality Assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(g) Business management and general administrative activities of the entity, including, but not limited to:

- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
- Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;
- Resolution of internal grievances; and
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

(h) Compliance with and preparation of all documents as required by ERISA, including Form 5500's, SAR's, and other documents. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

For purposes of this Plan, the Board of Trustees is the "Plan Sponsor." The Plan shall disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

(a) Not use or further disclose the information other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

(d) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

(e) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to the individual in accordance with the access requirements of HIPAA;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA; and

(j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; and

(h) 1f return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(a) The Plan Administrator, and

(b) Staff designated by the Plan Administrator.

The persons described above may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

If the persons described above do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and no other plan functions or benefits.

The Plan Sponsor will:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

(b) Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI;

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI; and

(e) Comply with the HIPAA Security and Breach Notification Rules, as applicable.

ARTICLE VIII. GENERAL PROVISIONS

8.1 Expenses

All reasonable expenses incurred in administering the Plan are paid by Employer contributions to the Fund and investment earnings on such contributions.

8.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Fund to the effect that such Employee will be employed for any specific period of time.

8.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Board of Trustees may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Board of Trustees or by any person or persons authorized by the Board of Trustees to take such action.

8.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of Michigan, to the extent not superseded by the Code, the Public Health Services Act or any other federal law.

8.5 Code and Other Applicable Law Compliance

It is intended that this Plan meet all applicable requirements of the Code and Public Health Services Act, applicable State law and of all regulations or administrative pronouncements issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and such laws, the provisions of such laws shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

8.6 No Guarantee of Tax Consequences

The Fund makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

8.7 Indemnification of Fund

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Fund for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

8.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

8.9 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

8.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

8.11 Plan Interpretation

The Board of Trustees is responsible for interpreting this Plan and for making determinations under this Plan as well as for controlling and managing the operation and administration of the Plan, including the creation and/or elimination of any notational HRA Plan account balance in accordance with the provisions of this Plan and the Agreement and Declaration of Trust. The Board of Trustees may delegate to persons or entities, including one or more insurance companies, who are not members of the Board of Trustees, any of its duties and responsibilities under this Plan and the Agreement and Declaration of Trust. In order to carry out

its responsibilities, the Board of Trustees or its designee shall have exclusive authority and discretion to determine all questions arising in the administration of the Plan which shall include the authority and discretion to:

(1) determine whether an individual is eligible to receive Benefits under this Plan;

(2) to calculate the amount of Benefits, if any, an individual is entitled to receive from this Plan;

(3) interpret and apply all of this Plan's provisions; and

(4) construe all of the terms used in this Plan.

All determinations and interpretations made by the Board of Trustees, or its designee, shall be final and binding upon any individual claiming Benefits from this Plan. Any such determinations and interpretations shall be given deference in all courts of law, to the greatest extent allowed by the applicable law and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith. All determinations by the Board of Trustees or its designee shall be based upon the criteria set forth in this Plan.

8.12 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

In Witness Whereof, this CDPSU Trust City of Detroit Retired Police and Fire Employees Health Reimbursement Arrangement Plan, established by the Board of Trustees of the Coalition of Detroit Public Safety Unions Trust Fund, effective April 1, 2017, is adopted after review and approval by the Trustees and is executed on their behalf on this 11 day of April, 2019.

Craig Miller

Mark Young

Aric Tosqui

Michael Nevin

Appendix A

Exclusions-Medical Expenses That Are Not Reimbursable

The HRA Plan document contains the general rules governing what expenses are reimbursable, at this time limiting reimbursable expenses only to medical, dental and visions insurance premiums paid by or on behalf of Participants and beneficiaries. This Appendix A, as referenced in the Plan document (Section 5.2(c)), specifies certain expenses that are not reimbursable under any circumstances, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Exclusions

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

(a) Long-term Care services/premiums.

(b) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(c) The salary expense of a nurse to care for a healthy newborn at home.

(d) Funeral and burial expenses.

(e) Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).

(f) Massage therapy.

(g) Home or automobile improvements.

(h) Custodial care.

(i) Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

(j) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

(k) Social activities, such as dance lessons (even though recommended by a physician for general health improvement).

(l) Bottled water.

(m) Maternity clothes.

(n) Diaper service or diapers.

(o) Cosmetics, toiletries, toothpaste, etc.

(p) Vitamins and food supplements, even if prescribed by a physician.

(q) Uniforms or special clothing, such as maternity clothing.

(r) Automobile insurance premiums.

(s) Transportation expenses of any sort, including transportation expenses to receive medical care.

(t) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

(u) Non-prescription OTC drugs and medicines including:

- Acid Controllers
- Allergy and Sinus
- Antibiotic products
- Anti-Diarrheals
- Anti-Gas
- Anti-Itch and Insect Bite
- Anti-parasitic Treatments

- Baby Rash
- Cold sore Remedies
- Cough, Cold and Flu
- Creams and/or Ointments
- Digestive Aids/Hemorrhoid Preps
- Laxatives
- Motion Sickness
- Pain Relief
- Respiratory Treatments
- Sleep Aids and Sedatives
- Stomach Remedies

(v) Any item that does not constitute "medical care" as defined under Code § 213(d) and the regulations thereunder.