Amended and Restated Health Reimbursement Arrangement Plan

November 1, 2023

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W I T N E S S E T H:

WHEREAS, the Ohio State Highway Patrol Retirement System (the "***System***" or "***HPRS***") established a health reimbursement arrangement to provide a reimbursement allowance to retirees who are eligible for Medicare ("***Medicare Retirees***"), effective October 1, 2021;

WHEREAS, the System now desires to provide a reimbursement allowance to retirees who are not yet eligible for Medicare ("***Pre-Medicare Retirees***"), as a component of its health reimbursement arrangement plan;

WHEREAS, the System is authorized by section 5505.28 of the Ohio Revised Code to establish a health reimbursement arrangement on behalf of certain retirees;

NOW THEREFORE BE IT RESOLVED, effective November 1, 2023, the System hereby amends and restates the Ohio State Highway Patrol Retirement System Health Reimbursement Arrangement Plan (the "***HPRS Plan***") to provide a reimbursement allowance to Pre-Medicare Retirees;

FURTHER RESOLVED, that the HPRS Plan is intended to be a retiree-only health reimbursement arrangement as defined under IRS Notice 2002-45 and IRS Revenue Ruling 2002-41, and the Qualifying Medical Expenses, as defined by the Code and applicable regulations, reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code sections 106 and 105(b);

FURTHER RESOLVED, that the reimbursements under the HPRS Plan shall be paid from the operating assets of the System or such other funding vehicle or mechanism established by the System.

ARTICLE I

DEFINITIONS

1.1 "***Administrator***" shall mean the Board.

1.2 "***Board***" shall mean the State Highway Patrol Retirement Board, as established by section 5505.04 of the Ohio Revised Code.

1.3 "***Child***" shall mean a biological child, lawfully adopted child, child placed for adoption or stepchild of a benefit recipient or member provided that such child has not attained the age of twenty-six (26), or is over the age of twenty-six and is disabled. For purposes of this definition, "disabled" shall mean the Child is all of the following: unmarried, mentally or physically incapable of earning his or her own living, and chiefly dependent upon the Eligible Retiree for support and maintenance. "Child" shall also mean a child for whom an Eligible Retiree has been legally appointed as guardian, provided that such child has not yet attained age eighteen (18).

1.4 "***CMS***" shall mean the Centers for Medicare and Medicaid Services.

1.5 "***Code***" shall mean the Internal Revenue Code of 1986, as amended, as applicable to governmental plans and applicable at such time to the Plan, and the regulations, revenue rulings, notices and other guidance promulgated thereunder.

1.6 "***Connector***" shall jointly refer to the retiree health care exchange for Eligible Pre-Medicare Retirees (hereinafter referred to as the "***Pre-Medicare Connector***") and the retiree health care exchange for Eligible Medicare Retirees (hereinafter referred to as the "***Medicare Connector***") operated by the Third-Party Administrator and its subcontractors.

1.7 "***Dependent***" shall mean a Spouse or Child who is considered a dependent for purposes of Code sections 105 and 106.

1.8 "***Effective Date***" shall mean November 1, 2023.

1.9 "***Electronic Protected Health Information***" shall have the same meaning as in 45 CFR section 160.103.

1.10 "***Eligible Dependent***" shall mean: (i) the surviving Spouse of a deceased Eligible Retiree, and (ii) the surviving Spouse of a deceased Member if the surviving Spouse is eligible to receive health care benefits pursuant to section 5505-7-04 of the Ohio Administrative Code. Eligible Dependent includes both Eligible Medicare Dependents and Eligible Pre-Medicare Dependents.

1.11 ***"Eligible Medicare Dependent"*** means an Eligible Dependent who is eligible for Medicare; provided however, that the following Eligible Dependents who are eligible for Medicare are excluded from the definition of Eligible Medicare Dependent: (i) an Eligible Dependent who is eligible for Medicare but within a coordination period associated with end stage renal disease;

and (ii) an Eligible Dependent who is eligible for Medicare but cannot access Medicare benefits due to permanent residence outside the Medicare coverage area.

1.12 ***"Eligible Pre-Medicare Dependent"*** shall mean (i) an Eligible Dependent who is not eligible for Medicare; (ii) an Eligible Dependent who is eligible for Medicare but within a coordination period associated with end stage renal disease, and (iii) an Eligible Dependent who is eligible for Medicare but cannot access Medicare benefits due to permanent residence outside the Medicare coverage area.

1.13 **"*Eligible Medicare Retiree*"** shall mean an Eligible Retiree who is eligible for Medicare; provided however that the following Eligible Retirees who are eligible for Medicare are excluded from the definition of Eligible Medicare Retiree: (i) an Eligible Retiree who is eligible for Medicare but within a coordination period associated with end stage renal disease; and (ii) an Eligible Retiree who is eligible for Medicare but cannot access Medicare benefits due to permanent residence outside the Medicare coverage area.

1.14 ***"Eligible Pre-Medicare Retiree"*** shall mean (i) an Eligible Retiree who is not eligible for Medicare; (ii) an Eligible Retiree who is eligible for Medicare but within a coordination period associated with end stage renal disease, and (iii) an Eligible Retiree who is eligible for Medicare but cannot access Medicare benefits due to permanent residence outside the Medicare coverage area.

1.15 "***Eligible Retiree***" shall mean a former Member who is included in one of the following:

(a) An age and service retirant who is described as one of the following:

(1) Prior to November 1, 2023, the retirant commenced and is receiving a pension pursuant to division (A)(1) of section 5505.17 of the Ohio Revised Code, or deferred retirement under section 5505.16 of the Ohio Revised Code, or elected to participate in the deferred retirement option plan pursuant to section 5505.51 of the Ohio Revised Code;

(2) On or after November 1, 2023, the retirant commenced and is receiving a pension pursuant to division (A)(1) of section 5505.17 of the Ohio Revised Code or elected to participate in the deferred retirement option plan pursuant to section 5505.51 of the Ohio Revised Code, and has accrued at least twenty (20) years of health care service credit, as defined in O.A.C. 5505-7-04.

(b) A disability retirant who applied for and was granted retirement benefits as described in section 5505.18 of the Ohio Revised Code.

"***Eligible Retiree***" includes both Eligible Medicare Retirees and Eligible Pre-Medicare Retirees.

1.16 "***Employee***" shall mean an individual defined in division (A) of section 5505.01 of the Ohio Revised Code.

1.17 "***Employer***" shall mean the Ohio State Highway Patrol.

1.18 ***"Health Care Coverage"*** shall mean group coverage provided through a medical benefits plan, a prescription drug benefits plan, a health reimbursement arrangement, and any other arrangement which provides a payment, stipend, or other remuneration of any kind for the purpose of obtaining minimum essential coverage, as defined in 26 C.F.R. 1.5000A-2. Coverage as a Participant in this Plan and COBRA continuation coverage are excluded from this definition.

1.19 "***Health Flexible Spending Account***" shall mean a health flexible spending arrangement as defined in Prop. Treasury Regulation section 1.125-5(a)(1).

1.20 "***HIPAA***" shall mean the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH Act enacted as part of the American Recovery and Reinvestment Act of 2009, and regulations adopted thereunder, as may be amended from time to time, including the "Privacy Rule" as set forth in the Standards for Privacy of Individually Identifiable Health Information codified at 45 CFR Parts 160 and 164, Subparts A and E, and the "Security Rule" set forth in the Standards for Security for the Protection of Electronic Protected Health Information, codified at 45 CFR parts 160, 162 and 164.

1.21 "***HPRS Plan***" or "***Plan***" shall mean the Ohio Highway Patrol Retirement System Health Reimbursement Arrangement Plan, which includes both the Medicare HRA and the Pre-Medicare HRA.

1.22 "***HRA Account***" shall mean the notional account maintained by the Administrator for a Participant in the Plan to which shall be credited contributions made pursuant to Subsection 3.2 of Addendum A and Subsection 3.2 of Addendum B.

1.23 "***Initial Enrollment Period***" shall mean the five (5) month time period beginning sixty (60) days prior to the first day of the month during which an Eligible Retiree or Eligible Dependent becomes eligible for participation in the Pre-Medicare HRA or the Medicare HRA, and ending sixty (60) days after the end of the month during which the Eligible Retiree or Eligible Dependent becomes eligible for participation in the Pre-Medicare HRA or the Medicare HRA. The System may modify the Initial Enrollment Period generally, or with respect to categories of eligible individuals or specific individuals, as the System determines, in its sole discretion, is appropriate based on specific facts and circumstances. Such modifications shall not require an amendment of the Plan.

1.24 "***Insurance Carrier***" shall mean an organization with which the Third-Party Administrator (or its affiliate) contracts to offer Medicare Plans through the Medicare Connector, and which is licensed to sell Medicare Plans in Ohio and other states where the organization sells Medicare Plans through the Medicare Connector.

1.25 "***Medicare HRA***" shall mean the provisions of the HPRS Plan which describe the benefits provided to Eligible Medicare Retirees and Eligible Medicare Dependents, and which for

ease of interpretation are set forth in Addendum B to the HPRS Plan document, which is hereby incorporated into and made a part of the HPRS Plan document.

1.26 "***MA Plan***" shall mean an individual Medicare Advantage Plan, issued by an Insurance Carrier pursuant to a contract with CMS, which does not include Medicare Part D prescription drug coverage.

1.27 "***MAPD Plan***" shall mean an individual Medicare Advantage Plan issued by an Insurance Carrier pursuant to a contract with CMS, which does include Medicare Part D prescription drug coverage.

1.28 "***Medicare***" shall mean the coverage provided under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B).

1.29 "***Medicare Cost Plan***" shall mean an individual Medicare plan issued by an Insurance Carrier pursuant to a contract with CMS under applicable law and which may or may not include Medicare Part D prescription drug coverage.

1.30 "***Medicare Part D Plan***" shall mean an individual prescription drug plan issued by an Insurance Carrier pursuant to a contract with CMS under applicable law, which solely supplements Medicare Part D prescription drug coverage.

1.31 "***Medicare Plan***" shall mean a MA Plan, a Medicare Supplemental Plan, a MAPD Plan, a Medicare Cost Plan, or a Special Needs Plan which is purchased through the Medicare Connector. An MA Plan, Medicare Supplemental Plan, MAPD Plan or Special Needs Plan shall not constitute a Medicare Plan for purposes of this Plan as of the date that it is no longer made available through the Medicare Connector.

1.32 "***Medicare Supplemental Plan***" shall mean an individual plan which supplements the benefits provided by Medicare, and which meets the requirements of a standard Medicare Supplemental Plan under applicable law.

1.33 "***Member***" shall have the same meaning as set forth in division (I) of section 5505.01 of the Ohio Revised Code.

1.34 "***Open Enrollment Period***" shall mean the annual period during which Eligible Retirees and Eligible Dependents who did not enroll during their Initial Enrollment Period may enroll in the HRA Plan. The Open Enrollment Period will be established by the System annually, and typically will occur during the fourth calendar quarter. The System will notify Eligible Retirees and Eligible Dependents of the Open Enrollment Period annually by any method reasonably determined by the System to efficiently and effectively provide notice.

1.35 "***Participant***" shall mean each Eligible Retiree and Eligible Dependent who participates in this Plan as provided in Addendum A or Addendum B. A Participant shall mean for purposes of Subsection 4.7 of Addendum A and Subsection 4.7 of Addendum B, a Participant who terminated participation in the Plan pursuant to Subsection 2.4(a)(i) of Addendum A and Subsection 2.4(a)(i) of Addendum B respectively.

1.36 "***Pre-Medicare HRA***" shall mean the provisions of the HPRS Plan which set forth the benefits provided to Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents, which for ease of interpretation are set forth in Addendum A to the HPRS Plan document, which is hereby incorporated into and made a part of the HPRS Plan document.

1.37 "***Plan Sponsor***" shall mean the System.

1.38 "***Plan Year***" shall mean the initial two (2) month period beginning on November 1, 2023 through December 31, 2023, which may also be referred to herein as the "Initial Plan Year". Beginning on January 1, 2024, "Plan Year" shall mean the calendar year.

1.39 "***Protected Health Information***" shall have the same meaning as in 45 CFR 160.103.

1.40 "***Qualifying Medical Expense***" shall mean an expense incurred by a Participant or the Dependent of such Participant, for medical care as defined in Code section 213(d) (including without limitation amounts paid for hospital, doctor, dental and vision care, drugs and premiums for accident and health insurance), but only to the extent that the Participant or Dependent, is not reimbursed for the expense through insurance or otherwise (other than under this Plan). Qualifying Medical Expense shall not include (i) expenses reimbursed or reimbursable under any private, employer-provided, other insurance, or any other accident or health plan, (ii) premiums for COBRA continuation coverage, (iii) expenses taken as a deduction on a Participant's federal income tax return, (iv) claims incurred prior to January 1, 2024, excluding claims for qualifying premium(s) for coverage beginning on or after January 1, 2024 which are paid between November 1, 2023 through December 31, 2023 to secure the coverage, and (v) claims incurred prior to becoming a Participant or after participation in the HRA has terminated, excluding claims for qualifying premiums paid for health care coverage which begins on or after the Participation Date of the Eligible Retiree or Eligible Dependent which are paid prior to the Participation Date to secure the coverage.

1.41 "***Reimbursement Allowance***" shall mean the amount credited to a Participant's HRA Account as provided for in Subsection 3.2 of Addendum A and Addendum B.

1.42 "***Special Needs Plan***" shall mean a Medicare Advantage coordinated care plan which targets individuals with special needs, issued by an Insurance Carrier pursuant to a contract with CMS.

1.43 "***Spouse***" shall mean an individual who is legally married to a Participant as determined under the laws of any state.

1.44 "***State***" shall mean the state of Ohio.

1.45 "***Summary Health Information***" shall have the same meaning as in 45 CFR section 160.504(a).

1.46 "***System***" shall mean the Ohio State Highway Patrol Retirement System.

1.47 "***Third-Party Administrator***" shall mean the individual or entity appointed by the Administrator to perform third party administrative services for the Plan.

ARTICLE II

PARTICIPATION AND ELIGIBILITY, FUNDING AND REIMBURSEMENT

2.1 Pre-Medicare HRA. The provisions governing participation and eligibility of Eligible Retirees and Eligible Dependents who are not yet eligible for Medicare, or who are eligible for Medicare but not eligible for the Medicare HRA as described in Subsections 1.12 and 1.14 of the HPRS Plan (collectively "***Pre-Medicare Eligible Individuals***"), determination and funding of Reimbursement Allowances for Pre-Medicare Eligible Individuals, termination of participation of Pre-Medicare Eligible Individuals and other similar terms applicable to Pre-Medicare Eligible Individuals are set forth in Addendum A, which is hereby incorporated into and made a part of this Plan.

2.2 Medicare HRA. The provisions governing participation and eligibility of Eligible Retirees and Eligible Dependents who are eligible for Medicare and not otherwise ineligible for the Medicare HRA as described in Subsections 1.11 and 1.13 of the HPRS Plan (collectively "***Medicare Eligible Individuals***"), determination and funding of Reimbursement Allowances for Medicare Eligible Individuals, termination of participation of Medicare Eligible Individuals and other similar terms applicable to Medicare Eligible Individuals are set forth in Addendum B, which is hereby incorporated into and made a part of this Plan.

ARTICLE III

CLAIM PROCEDURES

3.1 Claim Procedure. All claims for reimbursement and all other requests or questions under this Plan shall be presented and resolved pursuant to the following procedure:

(a) The Third-Party Administrator shall notify the Eligible Retiree, Eligible Dependent, Participant, or Dependent, as applicable, (the "***Claimant***") in writing of the claim determination, and if the claim is approved, pay the claim no later than thirty (30) days after receipt of the claim by the Plan. This period may be extended by the Third-Party Administrator for up to fifteen (15) days provided that the Third-Party Administrator determines that such extension is necessary due to matters beyond the control of the Plan, and the Claimant is notified prior to the expiration of the initial thirty (30) day period of circumstances requiring the extension of time and the date as of which the Third-Party Administrator expects to render a decision. If such extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically explain the additional information needed to decide the claim and then the Claimant shall be afforded at least forty-five (45) days within which to provide the specified information, and the notice of extension shall have the effect of suspending the time for a decision on the claim until the specified information is provided.

(b) The notice advising a Claimant that a claim has been denied in whole or in part shall: (i) specify the reason for denial, (ii) make specific reference to pertinent Plan provisions on which the denial is based, (iii) describe any additional material or information necessary for the Claimant to perfect the claim (explaining why such material or information is needed), and the time limit to submit the information, (iv) advise the Claimant of the Plan's appeal procedures and the applicable time limits for those procedures, (v) advise the Claimant of the internal rule, guideline, or protocol relied upon in making the adverse determination or that the protocol relied upon may be obtained by the Claimant free of charge upon request, (vi) provide an explanation of the scientific and clinical judgment for the determination if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, and (vii) provide a description of Claimant's right to request all documentation relevant to their claim.

The Plan provides one level of mandatory appeal for denied claims for reimbursements. All appeals shall be made by the following procedure:

(1) The Claimant, or the Claimant's authorized representative, whose claim has been denied shall file with the Third-Party Administrator a notice of desire to appeal the denial within one hundred eighty (180) days of receipt by the Claimant of the adverse benefit determination by the Third-Party Administrator. The appeal shall be made in writing, and shall set forth all of the facts upon which the appeal is based. Appeals not timely filed shall be barred.

(2) A Claimant, or Claimant's authorized representative, shall be provided a reasonable opportunity to appeal an adverse determination with the Third-Party Administrator

under which there will be a full and fair review of the claim and the adverse determination. Accordingly: (i) a Claimant will be provided the opportunity to submit written comments, documents, records or other information relating to the claim for reimbursements on appeal; (ii) a Claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for reimbursements; (iii) a Claimant may have an authorized representative act on the Claimant's behalf in pursuing a claim or appeal of an adverse determination; (iv) review on appeal will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim without regard to other such information once submitted or considered in the initial determination; (v) such appeal will not afford deference to the initial adverse determination and will be conducted by the Third-Party Administrator, which is an appropriate named fiduciary of the Plan and which shall neither be the individual who made the adverse determination that is subject to the appeal nor the subordinate of such individual; (vi) in the case of any appeal of an adverse determination that is based in whole or in part on a medical judgment, the Claimant shall be entitled to a review by the Third-Party Administrator based on the Third-Party Administrator's consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment whereby such professional is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal nor the subordinate of any such individual; and (vii) the Claimant will be provided with the identity of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Participant's adverse determination, without regard to whether the advice was relied upon in making the reimbursement determination.

(3) The Third-Party Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of reimbursements, and such other facts and circumstances, as the Third-Party Administrator shall deem relevant.

(4) The Third-Party Administrator shall render a determination upon the appealed claim within sixty (60) days after receipt of the Claimant's request for review, unless the Third-Party Administrator determines that special circumstances require an extension of time for processing the claim, in which case the Claimant shall be given a written notification within such initial sixty (60) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred eighty (180) days after the date on which the request for review was filed). The determination shall be written in a manner calculated to be understood by the Claimant and shall: (i) include the reason for denial, (ii) make specific reference to pertinent Plan provisions on which the denial is based, (iii) describe any additional material or information necessary for the Claimant to perfect the claim (explaining why such material or information is needed), and the time limit to submit the information, (iv) advise the Claimant of the Plan's appeal procedures and the applicable time limits for those procedures, (v) advise the Claimant of the internal rule, guideline, or protocol relied upon in

making the adverse determination or that the protocol relied upon may be obtained by the Claimant free of charge upon request, (vi) provide an explanation of the scientific and clinical judgment for the determination if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, and (vii) provide a description of Claimant's right to request all documentation relevant to their claim.

(5) The determination so rendered shall be binding upon all parties. If the outcome of the appeal is adverse to the Claimant, the Claimant may be eligible for an independent external review pursuant to federal law. The Claimant must submit a written request for external review to the Plan Administrator within four (4) months of the notice of the internal appeal determination.

The Claimant may not file suit until the appeal procedures described above have been completed and all administrative procedures under the Plan have been exhausted.

(6) The Administrator has determined that due to the nature of this Plan, there will be no pre-service claims or urgent claims, and all claims and appeals under this Plan shall constitute post-service claims. Notwithstanding the foregoing, to the extent that a claim or appeal is received by the Plan that constitutes an urgent care request, a pre-service request or a concurrent claim, the time periods set forth in this Section 3.1 shall be adjusted to reflect the applicable time periods set forth in Department of Labor regulation section 2560.503-1.

3.2 Exhaustion of Administrative Remedies and Pursuit of Legal Action. The exhaustion of the claim procedure in this Article III is mandatory for resolving every claim and dispute arising under this Plan. Claimant, or the authorized representative may not pursue any legal action or equitable remedy otherwise available after the expiration of two (2) years from the date of the written final adverse determination as provided in Section 3.1.

ARTICLE IV

CONTINUATION COVERAGE UNDER COBRA

4.1 Definitions. For purposes of this Article IV, the following definitions shall apply:

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

(b) "***Continuation Coverage"*** means the Plan coverage elected by a Qualified Beneficiary under COBRA. This coverage, which as of the time the coverage is being provided, shall be identical to the coverage provided to similarly situated beneficiaries under the Plan with respect to whom a Qualifying Event has not occurred as of the date the Qualified Beneficiary experiences a Qualifying Event.

(c) "***Continuation Coverage Contribution***" means the amount of premium contribution required to be paid by a Qualified Beneficiary for Continuation Coverage.

(d) "***Covered Participant***" means an Eligible Retiree or an Eligible Dependent covered under the Plan on the day prior to the Qualifying Event.

(e) "***Group Health Plan***" has the same meaning as that term is defined in COBRA and the regulations thereunder.

(f) "***Qualified Beneficiary***" means, except as provided in Subsection 4.7(a)(1) of Addendum A and Addendum B, a Spouse or Child of a Covered Participant who was covered under the Plan on the day prior to the Qualifying Event. The term Qualified Beneficiary shall include a Child who is born to, adopted by, or placed for adoption with the Covered Participant during a period of Continuation Coverage.

(g) "***Qualifying Event***" means, except as provided in Subsection 4.7(a)(1) of Addendum A and Addendum B, the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

(1) The death of a Covered Participant;

(2) The divorce or legal separation of the Covered Participant from the Spouse; or

(3) A Child ceasing to be eligible as a Dependent under the terms of the Plan.

4.2 Right to Elect Continuation Coverage. If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, the Qualified Beneficiary may elect to continue coverage under the Plan in accordance with COBRA upon payment of the Continuation Coverage Contribution specified from time to time by the System. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of the date of the Qualifying Event, or the date the Qualifying Beneficiary was notified of the right to continue coverage.

4.3 Notification of Qualifying Event. If the Qualifying Event is divorce, legal separation or a Child's ineligibility under the Plan, the Qualified Beneficiary must notify the System of the Qualifying Event within sixty (60) days of the event in order for coverage to continue. Failure to make timely notification will terminate the Qualified Beneficiary's right to Continuation Coverage under this Article IV.

4.4 Length of Continuation Coverage. A Qualified Beneficiary who loses coverage due to a Qualifying Event may continue coverage under the Plan for up to thirty-six (36) months from the date of the Qualifying Event, or for such other period as prescribed by COBRA and the Ohio Revised Code and the administrative pronouncements promulgated thereunder.

4.5 Termination of Continuation Coverage. Continuation Coverage will automatically end earlier than the thirty-six (36) month period for a Qualified Beneficiary if:

(a) The required Continuation Coverage Contribution is not received by the System within thirty (30) days following the date it is due (or, in the case of the initial payment, within forty-five (45) days of the due date for the initial payment);

(b) The Qualified Beneficiary becomes covered under any other Group Health Plan (other than this Plan) as an employee or otherwise. This provision applies to all Qualifying Events;

(c) The Qualified Beneficiary becomes entitled to Medicare benefits; or

(d) The System or Employer ceases to offer any Group Health Plans.

4.6 Continuation Coverage. The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated individuals. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of dependent under the Plan.

4.7 Payment of Continuation Coverage Contribution.

(a) The Plan will determine the amount of the monthly Continuation Coverage Contribution for any period, which will be a reasonable estimate of the Plan's cost of providing coverage for such period for similarly situated individuals for whom a Qualifying Event has not occurred, determined on an actuarial basis and considering such factors as the Secretary of Health and Human Services may prescribe. The Continuation Coverage Contribution is the same for Qualified Beneficiaries with different total reimbursement amounts available from the Plan. The Plan may require a Qualified Beneficiary to pay a Continuation Coverage Contribution that does not exceed one hundred two (102) percent of the applicable premium for that period.

(b) If Continuation Coverage is elected, the first monthly Continuation Coverage Contribution must be made within forty-five (45) days of the date of election.

(c) Without further notice from the System, the Qualified Beneficiary must pay the Continuation Coverage Contribution by the first day of the month for which coverage is to be effective. If payment is not received by the System within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with Section 4.5(a) above.

(d) No claim will be payable under this provision for any period for which the Continuation Coverage Contribution is not received from or on behalf of the Qualified Beneficiary by the due dates specified in this Section 4.7.

4.8 Bankruptcy under Title XI.

(a) For purposes of this Section 4.8 only:

(1) "***Qualified Beneficiary***" means (i) a Covered Participant who was covered under the Plan as an Eligible Retiree and who retired on or before the date of the Qualifying Event, (ii) a Covered Participant who was covered under the Plan as an Eligible Dependent on the day before the date of the Qualifying Event, and (iii) an individual who was covered under the Plan as a Spouse or Child on the day before the date of the Qualifying Event.

(2) "***Qualifying Event***" means the substantial elimination of coverage under the Plan within one year before or after the System files a petition in bankruptcy under Title XI of the United States Code.

(b) If a Qualified Beneficiary experiences a Qualifying Event as defined in this Section, the Qualified Beneficiary may elect to continue coverage under the Plan if he/she pays the Continuation Coverage Contribution specified from time to time by the System, and makes the election in accordance with Section 4.2 above.

(c) Continuation Coverage for a Qualified Beneficiary who is an Eligible Retiree or an Eligible Dependent will continue for the life of such Qualified Beneficiary. Continuation Coverage for a Qualified Beneficiary who is a Spouse or Child will continue for the life of the Eligible Retiree or Eligible Dependent and for up to thirty-six (36) months after the death of the Eligible Retiree or Eligible Dependent.

(d) Continuation Coverage elected under this Section will automatically end earlier than the periods specified above if the required Continuation Coverage Contribution is not paid on a timely basis or if the System ceases to offer any Group Health Plans.

ARTICLE V

PROVISION OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR

5.1 Permitted and Required Uses and Disclosure of Protected Health Information. Subject to obtaining written certification pursuant to Section 5.3 of the HPRS Plan, the Plan may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

(a) To perform Plan administrative functions which the Plan Sponsor performs for the Plan; or

(b) Modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR section 164.504(f).

5.2 Conditions of Disclosure. The Plan shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions, conditions, and security measures that apply to the Plan Sponsor with respect to Protected Health Information or Electronic Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.

(c) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the Plan Sponsor or other entity adopting the Plan, unless the benefit plan is a health plan, as that term is defined at 45 CFR section 160.103, and is part of an organized health care arrangement which includes the Plan.

(d) Report to the Plan any use or disclosure of a Participant's Protected Health Information that is inconsistent with the uses or disclosures allowed under the Plan document of which it becomes aware.

(e) Make available to a Participant who requests access the Participant's Protected Health Information in accordance with 45 CFR section 164.524.

(f) Make available to a Participant who requests an amendment, the Participant's Protected Health Information and incorporate any amendments to the Participant's Protected Health Information in accordance with 45 CFR section 164.526.

(g) Make available to a Participant who requests an accounting of disclosures of the Participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

(h) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR section 164.504(f).

(i) If feasible, return or destroy all Protected Health Information 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 the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

(j) Ensure that the adequate separation between the Plan and the Plan Sponsor required in 45 CFR section 164.504(f)(2)(iii) is satisfied.

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan.

(l) Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 CFR §164.304 as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

5.3 Certification of Plan Sponsor. Except for Summary Health Information and enrollment and disenrollment information, the Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR section 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 5.2 above.

5.4 Permitted Uses and Disclosure of Summary Health Information. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor without receipt of a Plan Sponsor Certification, provided the Summary Health Information is only used by the Plan Sponsor for the purpose of obtaining premium proposals for health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan.

5.5 Permitted Uses and Disclosure of Enrollment and Disenrollment Information. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor without receipt of a Plan Sponsor certification.

5.6 Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only allow access to Protected Health Information or Electronic Protected Health Information by

employees of the Plan Sponsor who have a role in administration of the Plan. Such employees shall only have access to and use such Protected Health Information or electronic Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that such employee does not comply with the provisions of this Section 5.6, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. The Plan Sponsor shall implement reasonable and appropriate security measures to limit access to Electronic Protected Health Information and Protected Health Information to the appropriate employees who have a role in Plan administration.

5.7 Security Measures for Electronic Protected Health Information. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a covered individual's Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains, or transmits on the Plan's behalf. The Plan Sponsor shall report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware.

5.8 Terms. Any term used in this Article V shall have the meaning set forth in HIPAA and guidance issued thereunder.

ARTICLE VI

ADMINISTRATION OF THE PLAN

6.1 Powers and Authority of the System. The System shall have the full power and authority to control and manage the operation and proper administration of the Plan. Such power and authority shall include, but not be limited to, doing or causing to be done the following:

(a) To appoint and remove, by written notice to such person, the Third-Party Administrator, or successor Third-Party Administrator from time to time as it deems necessary.

(b) To provide the Third-Party Administrator with complete and timely information on matters of Eligible Retirees and Eligible Dependents and other facts necessary to the Third-Party Administrator's proper performance of its duties.

6.2 Powers and Authority of the Administrator. The Administrator shall have full power to construe the terms of this Plan, and the authority (including discretion with respect to the exercise of that power and authority) to control and manage the operation and administration of this Plan. Such power and authority of the Administrator shall include, but not be limited to, doing or causing to be done the following:

(a) To furnish Participants with summary plan descriptions and other information as required to be furnished under the Code or the Ohio Revised Code or as otherwise deemed proper;

(b) To prepare and file any reports, notifications, registrations, and other disclosures required by the Code, the Ohio Revised Code or other applicable laws;

(c) To appoint, retain, employ or otherwise consult with legal counsel, qualified public accountants and other advisors and agents (any of which may be appointed, retained or employed by the System), and to allocate such responsibilities, powers and authority in the administration of this Plan as deemed necessary or advisable;

(d) To determine eligibility to participate in the Plan and other determinations required hereunder in the administration of this Plan, including the validity of claims, and to notify the Participants of the same;

(e) To establish rules, regulations, and procedures with respect to administration of the Plan, not inconsistent with the Plan and the Code, and to amend or rescind such rules, regulations, or procedures;

(f) To establish and maintain such separate accounts and accountings in respect of each Participant as may be required by the Plan;

(g) To prescribe procedures to be followed and the forms to be used to enroll in and submit claims pursuant to this Plan;

(h) To prepare and distribute information explaining this Plan and reimbursements under this Plan in such manner as the Administrator determines to be appropriate;

(i) To request and receive from all Participants such information as the Administrator determines reasonable and appropriate;

(j) To make such distributions at such time or times to such Participants and beneficiaries as shall be directed or as otherwise required pursuant to the terms of the Plan;

(k) To keep full and accurate records showing all receipts, expenses, distributions and payments and complete records of the administration and operation of the Plan which may be examined at any time during regular business hours, and summary copies of which shall be furnished to the System at such periodic intervals as may be agreed upon, but not less frequently than annually;

(l) Not to engage in any transaction, nor to cause the Plan to engage in any transaction, nor to deal in any way with the assets set aside for the Plan, which are prohibited by the provisions of the Code or the Ohio Revised Code applicable to fiduciaries of employee welfare benefit plans;

(m) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(n) To interpret this Plan, to promulgate rules regarding the administration of this Plan, to determine all questions regarding eligibility, participation, benefits, reimbursements and coverage, to control its own proceedings, and to correct any defect, supply any omission, or reconcile any inconsistency in the Plan with respect to the same; and

(o) To exercise all powers and authority conferred upon it herein, and to perform all acts and exercise all discretion as may be deemed necessary for or incidental to the administration of this Plan as long as consistent with the objectives hereof and the requirements of the Code and the Ohio Revised Code.

6.3 Appointment of Advisors. Notwithstanding anything to the contrary, the Administrator shall have the power, discretion, and authority to employ, appoint or otherwise designate such other person or persons (including any office, department, or other personnel of the System) to carry out such of its responsibilities as Administrator under this Plan as the Administrator in its sole discretion deems appropriate, and the Administrator may delegate to and otherwise allocate among such other persons as so designated by it any of the power and authority of the Administrator hereunder for the operation and administration of the Plan.

6.4 Compensation and Expenses. No employee of the System shall be compensated for services performed in connection with the administration of the Plan. However, all reasonable expenses of the employees of the System incurred in connection with the administration of the Plan shall be borne by the System.

6.5 Correction of Errors. If any reimbursement has been made in error or if any notional contributions to an HRA Account are determined to be in error, the System shall have the authority to correct such errors.

6.6 Limitation on Recovery. Participants, Eligible Retirees, Eligible Dependents, Spouses and Dependents may not seek recovery against the Administrator or System, or any employee, contractor, or agent of the Employer, Administrator, or System for any loss sustained by any Participant, Eligible Retiree, Eligible Dependent, Spouse or Dependent due to the nonperformance of their duties, negligence, or any other misconduct of the above named persons. This paragraph shall not, however, excuse fraud or a wrongful taking by any person.

6.7 Payment of Expenses. All reasonable expenses of administration of the Plan and any trust forming a part thereof shall be paid by the System. The System, Board, and Employers shall not be responsible for any such ministerial expense.

ARTICLE VII

AMENDMENT AND TERMINATION

7.1 Amendment. The System shall have the right at any time and from time to time to amend, modify, or terminate, in whole or part, any or all of the provisions of this Plan. Any amendment of the Plan made in accordance with this Section may be made retroactively if deemed necessary or appropriate by the System.

7.2 Termination. Although it is the expectation of the System that this Plan will continue indefinitely, the Board shall have the right, notwithstanding any other provision contained herein, at any time to terminate this Plan. In the event of such termination, the assets of this Plan shall be dispersed as required by law.

ARTICLE VIII

MISCELLANEOUS

8.1 Non-alienation. Unless otherwise required by law, the benefits provided by this Plan shall not in any way directly or indirectly be assignable, alienable or subject to attachment, execution, garnishment, operation of bankruptcy or insolvency laws, or other legal or equitable process, either voluntarily or involuntarily. Notwithstanding the above, the Administrator in its sole discretion may pay any benefit of a Participant directly to a third-party provider of services of a type covered by such benefit.

8.2 Inability to Locate Payee. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

8.3 Overpayments. If a person who is a Participant, former Participant or Dependent, as defined in this Plan, is paid any benefit or payment by the Administrator or Third-Party Administrator to which the person is not entitled, the overpaid amount shall be repaid to the Administrator or Third-Party Administrator by the person. If the person fails to make the repayment, the Administrator or Third-Party Administrator shall withhold the amount due from any benefit due the person or may collect the amount in any other manner provided by law.

8.4 No Guarantee of Tax Consequences. Neither the Administrator nor the System makes any 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.

8.5 Rescission of Coverage. The Eligible Retiree's, Eligible Dependent's or Participant's eligibility for participation in the Plan shall be rescinded if the individual, Spouse or Dependent is convicted of falsification under section 2921.13 of the Ohio Revised Code regarding the Plan or performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact regarding the coverage or plan. The effective date of the termination of Plan participation shall be the earlier of the date of the conviction or the act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact, unless otherwise limited by Ohio law. The System shall notify the individual of the rescission at least thirty (30) days prior to processing the rescission. The rescission of a Participant's participation applies to the Participant's Spouse and Dependents.

8.6 Legal Proceedings. No action at law or in equity shall be brought to recover benefits under the Plan:

(a) Prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the claim procedures of Article IIIIII of the HPRS Plan;

(b) More than three (3) years from the expiration of the time within which proof of claim is required by the Plan; and

(c) Unless the Participant claiming benefits shall have first exhausted the administrative remedies by filing proof of claim and pursuing an appeal under the terms provided in the Plan.

8.7 Facility of Payment. Whenever a Participant or provider to whom payments are directed to be made is determined to be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the System nor the Administrator shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. If a Participant to whom a payment would otherwise be due is deceased, the System or the Administrator may make such payment to the estate or personal representative of such Participant. A determination of payment made in good faith shall be conclusive on all persons. The System and the Administrator shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Nothing herein shall restrict or impair the right of the System to recover any excess or duplicate payment or payment made in error.

8.8 Limitation of Rights. Nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Employer, Administrator, or the System, except as expressly provided herein or required by law.

8.9 Release. Any payment to any Participant or Dependent shall, to the extent thereof, be in full satisfaction of the claim of such Participant or Dependent and the Administrator may condition payment thereof on the delivery by the Participant or Dependent of a duly executed receipt and release in such form as may be determined by the Administrator.

8.10 Liability. The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document, or electronic transmission, believed by the Administrator to be genuine or to be executed or sent by an authorized person.

8.11 Necessary Parties. Necessary parties to any accounting, litigation, or other proceedings relating to the Plan shall include only the Administrator. The settlement or judgment in any such case in which the Board is served shall be binding upon all affected Participants in the Plan, their Dependents, estates, and upon all persons claiming by, and through, or under them.

8.12 Severability. If any provision of the Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan shall continue to be fully effective.

8.13 Supersession. The terms of this Plan shall supersede any previous agreement between entities or individuals pertaining to the Plan.

8.14 Construction. This Plan shall be construed:

(a) Under the laws of the State of Ohio and consistent with the requirements under the Code and other requirements of law as may then be in effect and applicable to this Plan.

(b) Such that any words used in any gender shall include the masculine, feminine and neuter, although this document is intended to be gender neutral, and any terms defined in the singular shall include the plural and *vice versa*, all references to "Section" refer to this Plan unless the context otherwise requires.

(c) Such that the headings and subheadings of this Plan are for convenience only and are to be ignored in the construction of any provisions thereof.

IN WITNESS WHEREOF, the System has adopted this Plan this 24th day of October, 2023.

STATE HIGHWAY PATROL RETIREMENT SYSTEM

By: Carl Roark
Carl Roark

Its: Executive Director

ADDENDUM A

Pre-Medicare HRA Provisions

SECTION 1.
PREAMBLE

1.1 Pre-Medicare HRA Provisions. This Addendum A, which is hereby incorporated into and made a part of the Plan, sets forth the terms and conditions of the Plan applicable to Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents. Terms and conditions applicable to Eligible Medicare Retirees and Eligible Medicare Dependents are set forth in Addendum B to the Plan. This Addendum A is hereinafter referred to as the "***Pre-Medicare HRA***."

1.2 Definitions. Unless otherwise defined in this Addendum A, capitalized terms used in this Addendum A have the same meaning as set forth in Article I of the HPRS Plan.

SECTION 2.
PARTICIPATION AND ELIGIBILITY

2.1 Eligibility for Participation.

(a) Eligible Pre-Medicare Retiree. Each Eligible Pre-Medicare Retiree shall be eligible to become a Participant in the Pre-Medicare HRA on the later of: (i) the Eligible Pre-Medicare Retiree's effective date of retirement benefits as set forth in section 5505-3-01 of the Ohio Administrative Code; or (ii) the Eligible Pre-Medicare Retiree's effective date of disability benefits as set forth in section 5505-3-01 of the Ohio Administrative Code ("***Pre-Medicare Eligible Retiree Eligibility Date***").

(b) Eligible Pre-Medicare Dependent. Each Eligible Pre-Medicare Dependent shall be eligible to become a Participant in the Pre-Medicare HRA on the date the Eligible Pre-Medicare Dependent is eligible to receive health care benefits pursuant to section 5505-7-04 of the Ohio Administrative Code ("***Pre-Medicare Eligible Dependent Eligibility Date***"); provided however, that if an Eligible Pre-Medicare Dependent has other Health Care Coverage available through an employer (as an active employee, retiree or spouse), or through a state or federal retirement system, whether or not such other Health Care Coverage is elected, such Eligible Pre-Medicare Dependent shall not be eligible to become a Participant in the Pre-Medicare HRA.

(c) Eligibility Date. The Pre-Medicare Eligible Retiree Eligibility Date and Pre-Medicare Eligible Dependent Eligibility Date are collectively referred to hereinafter as "***Eligibility Date***".

2.2 Enrollment in the Pre-Medicare HRA and Effective Date. An Eligible Pre-Medicare Retiree who satisfies the requirements of Subsection 2.1(a) of this Addendum A and an Eligible Pre-Medicare Dependent who satisfies the requirements of Subsection 2.1(b) of this Addendum A may elect to enroll in the Pre-Medicare HRA as a Participant by completing any enrollment form and enrollment procedures specified by the System ("***Enrollment Requirements***"). Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents with an Eligibility Date on or before January 1, 2024 must complete the Enrollment Requirements between November 1, 2023 and December 15, 2023. Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents with an Eligibility Date after January 1, 2024 must enroll in the Pre-Medicare HRA during their Initial Enrollment Period. Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents who do not complete the Enrollment Requirements within the time limits set forth above may not enroll in the Pre-Medicare HRA until the next Open Enrollment Period, unless the Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent qualifies for a Special Enrollment Period as set forth in Subsection 2.2(c) of this Addendum A. The effective date of participation for Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents as set forth in Subsection 2.2 (a) through (c) below is referred to hereinafter as the "***Participation Dat***e")

(a) Effective Date for Eligible Pre-Medicare Retirees ("***Participation Date***"). The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Retiree who completes the Enrollment Requirements between November 1, 2023 and December 15, 2023 shall be the first day of the month during which the Eligible Pre-Medicare Retiree completes the Enrollment Requirements. The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Retiree who completes the Enrollment Requirements after December 15, 2023 and during their Initial Enrollment Period is the later of (i) the retirement benefits or disability benefits eligibility date, as set forth in OAC 5505-3-01 ("***Eligibility Date***"), or if the Eligibility Date is other than the first day of a month, the first day of the month following the Eligibility Date; or (ii) the first day of the first month after the Eligible Medicare Dependent has completed the Enrollment Requirements. The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Retiree who completes the Enrollment Requirements during an Open Enrollment Period is the first day of the Plan Year following the Open Enrollment Period during which the Eligible Pre-Medicare Retiree first completes the Enrollment Requirements.

(b) Effective Date for Eligible Pre-Medicare Dependents ("***Participation Date***"). The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Dependent who completes the Enrollment Requirements between November 1, 2023 and December 15, 2023 shall be the first day of the month during which the Eligible Pre-Medicare Dependent completes the Enrollment Requirements. The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Dependent who completes the Enrollment Requirements after December 15, 2023 and during their Initial Enrollment Period is the later of (i) the first day of the first month after the death of the deceased Eligible Retiree or deceased Member ("***Eligibility Date***"); or (ii) the first day of the first month after the Eligible Medicare Dependent has completed the Enrollment Requirements. The effective date of participation in the Pre-Medicare HRA for an Eligible Pre-Medicare Dependent who completes the Enrollment Requirements during an Open Enrollment Period is the first day of

the Plan Year following the Open Enrollment Period during which the Eligible Pre-Medicare Dependent first completes the Enrollment Requirements.

(c) Special Enrollment Periods. An Eligible Pre-Medicare Retiree or an Eligible Pre-Medicare Dependent may enroll during the Plan Year within sixty (60) days of termination of coverage or change in circumstances, as defined by the Internal Revenue Service, or a change in circumstances that affects eligibility for a premium tax credit, and with proof of such termination of coverage or change of eligibility or circumstances, as described in section 36B of the Code ("***Special Enrollment Period***"). The effective date of participation in the Pre-Medicare HRA (***"Participation Date"***) for an Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent who is entitled to a Special Enrollment Period and who completes the Enrollment Requirements prior to the end of the Special Enrollment Period is the first day of the month after the Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent completes the Enrollment Requirements.

2.3 Exclusions From Participation. The following persons shall not be eligible to participate in the Pre-Medicare HRA: (i) any Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent who is employed or re-employed as an Employee of the Employer; (ii) any Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent who voluntarily terminates enrollment or waives all Reimbursement Allowances and reimbursements; (iii) any recipient of a survivor benefit who does not satisfy the definition of an Eligible Pre-Medicare Dependent; and (iv) any Eligible Pre-Medicare Dependent who has other Health Care Coverage available through an employer (as an active employee, retiree or spouse), or through a state or federal retirement system, whether or not such other Health Care Coverage is elected. In addition, any Eligible Retiree or Eligible Dependent who is eligible for Medicare (except as provided in Article I, Sections 1.12 and 1.14 of the HPRS Plan), whether or not the Eligible Retiree or Eligible Dependent has enrolled in Medicare, shall not be eligible for a Reimbursement Allowance under the Pre-Medicare HRA; provided however that such Eligible Retiree or Eligible Dependent shall be eligible for a Reimbursement Allowance under the Medicare HRA upon completion of the Enrollment Requirements for the Medicare HRA.

2.4 Termination of Participation.

(a) Generally. A person shall cease to be a Participant in the Pre-Medicare HRA on the earlier of (i) the Participant's date of death, (ii) the first day of the calendar month following the Participant's employment or re-employment as an Employee of the Employer; (iii) the first day of the month following the Participant's election to terminate enrollment and waive all Reimbursement Allowances and reimbursements; or (iv) the date on which the Pre-Medicare HRA or the Plan is terminated by the System. Reimbursements from the Participant's HRA Account after termination of the Participant's participation shall be governed by Section 4 of this Addendum A.

(b) Termination of Medicare Eligible Participants. A Participant becomes ineligible to receive a Reimbursement Allowance under the Pre-Medicare HRA as of the first day of the calendar month the Participant becomes eligible for Medicare (except as provided in Article I, Sections 1.12 and 1.14 of the HPRS Plan), whether or not the Participant enrolls in Medicare; provided however, that the Participant is eligible to receive a Reimbursement

Allowance under the Medicare HRA upon timely completion of the Enrollment Requirements under the Medicare HRA. If a Participant who becomes eligible for Medicare upon attaining Medicare age fails to complete the Enrollment Requirements under the Medicare HRA on a timely basis, the Participant's participation in the Plan shall terminate as of the first day of the calendar month the Participant becomes eligible for Medicare (except as provided in Article I, Sections 1.12 and 1.14 of the HPRS Plan), whether or not the Participant has enrolled in Medicare.

With regard to a Participant who becomes eligible for Medicare prior to attaining Medicare age, such Participant shall notify the System of their Medicare eligibility within thirty (30) days of being notified by CMS of said eligibility, and eligibility to receive a Reimbursement Allowance under the Pre-Medicare HRA ceases on the later of the effective date of Medicare or the first day of the third month following the Participant's receipt of notice of eligibility for Medicare, regardless of whether the Participant has enrolled in Medicare; provided however that the Participant is eligible to receive a Reimbursement Allowance under the Medicare HRA upon timely completion of the Enrollment Requirements under the Medicare HRA. If a Participant: (i) fails to inform the System of their Medicare eligibility within thirty (30) days of receipt of notice of eligibility for Medicare, or (ii) notifies the System of their Medicare eligibility within thirty (30) days of receipt of notice of eligibility for Medicare but fails to enroll in Medicare or timely complete the Enrollment Requirements under the Medicare HRA, the Participant's right to receive a Reimbursement Allowance under the Pre-Medicare HRA and participation in the Plan shall terminate retroactively as of the earliest date the Participant might have enrolled in Medicare. Reimbursements from the Participant's HRA Account after termination of the Participant's participation in the Plan shall be governed by Section 4 of this Addendum A.

SECTION 3

FUNDING OF REIMBURSEMENT ALLOWANCE

3.1 System's Source of Funding. The coverage under this Pre-Medicare HRA shall be funded by and paid from the operating assets of the System or any such other funding vehicle or mechanism established by the Board on behalf of Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents. Nothing herein will be construed to require the System or the Administrator 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 System from which any payment under this Pre-Medicare HRA may be made. An HRA Account shall be established for each Eligible Pre-Medicare Retiree and each Eligible Pre-Medicare Dependent who satisfies the requirements of Section 2 of this Addendum A and completes the Enrollment Requirements of Subsection 2.2 of this Addendum A. In no event shall coverage under this Pre-Medicare HRA be funded with Participant contributions.

3.2 Reimbursement Allowance.

(a) Eligibility for Reimbursement Allowance. Provided that the Participant continues to meet the requirements of Section 2 of this Addendum A and has on file with the Administrator a written authorization to permit the direct deposit of reimbursement payments

to an account with an appropriate financial institution, or has received the necessary exemption from direct deposit, a Participant is eligible for a monthly Reimbursement Allowance.

(b) Reimbursement Allowance Amount. The System, in its sole discretion, may provide a monthly Reimbursement Allowance beginning on January 1, 2024 with respect to: (i) each Participant who is an Eligible Pre-Medicare Retiree and who satisfies the requirements of Section 2 of this Addendum A as applicable to an Eligible Pre-Medicare Retiree, and (ii) each Participant who is an Eligible Pre-Medicare Dependent and who satisfies the requirements of Section 2 of this Addendum A, as applicable to an Eligible Pre-Medicare Dependent. The System by action of its Board shall determine from time to time the amount of the Reimbursement Allowance an Eligible Pre-Medicare Retiree is entitled to receive, and may vary the Reimbursement Allowance amount for Eligible Pre-Medicare Retirees based on the Eligible Pre-Medicare Retiree's healthcare service credit, as further defined in O.A.C. 5505-7-04. The System by action of its Board shall determine from time to time the amount of Reimbursement Allowance an Eligible Pre-Medicare Dependent is entitled to receive, and the amount of Reimbursement Allowance shall be the same for all Eligible Pre-Medicare Dependents, regardless of the healthcare service credit accrued by the Eligible Pre-Medicare Dependent's deceased Spouse. In addition to the monthly Reimbursement Allowance beginning on January 1, 2024, the System, by action of its Board, may in its sole discretion approve from time to time an ad hoc Reimbursement Allowance for Eligible Pre-Medicare Retirees, Eligible Pre-Medicare Dependents or both. Upon approval by the Board of the amount of Reimbursement Allowance Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents are entitled to receive, the System shall notify Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents of such approved amounts, and such approved amounts shall be automatically incorporated into the Plan. Notification of Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents of the amount of the Reimbursement Allowance by the System may be by any method reasonably determined by the System to efficiently and effectively provide notice.

(c) Crediting Reimbursement Allowance. For any calendar month that the System has determined to provide a monthly Reimbursement Allowance on behalf of a Participant (or other time period during which an ad hoc Reimbursement allowance is provided), the amount of such Reimbursement Allowance will be notionally credited to the Participant's HRA Account at the beginning of such calendar month or other time period. If a Participant fails to maintain on file with the Administrator for one or more months a written authorization to permit the direct deposit of reimbursement payments to an account with an appropriate financial institution, or an exemption from direct deposit, as required under Subsection 3.2(a), the Reimbursement Allowance for that month or months shall not be credited to the Participant's HRA Account until a written authorization to permit the direct deposit of reimbursement payments to an account with an appropriate financial institution is provided to the System, or an exemption from direct deposit is obtained.

(d) Periodic Ineligibility for a Reimbursement Allowance. If (i) a Participant fails to satisfy the eligibility requirements to receive a Reimbursement Allowance as set forth in Section 2 of this Addendum A for any full calendar month, or (ii) a Participant, Eligible Retiree or Eligible Dependent waives the Reimbursement Allowance and reimbursements for one or more full calendar months, or (iii) a Participant, Eligible Pre-Medicare Retiree or

Eligible Pre-Medicare Dependent is employed or re-employed by the Employer for one or more full calendar months, the Participant, Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent shall not be entitled to a Reimbursement Allowance for such month(s). If such Participant, Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent subsequently satisfies the eligibility requirements, withdraws the waiver of a Reimbursement Allowance and reimbursements or terminates employment or reemployment by the Employer for one or more subsequent full calendar months, such Participant, Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent shall resume receiving a Reimbursement Allowance for each subsequent month thereafter in which the eligibility requirements are satisfied. The Participant, Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent shall not be entitled to a retroactive Reimbursement Allowance for any calendar month in which such Participant, Eligible Pre-Medicare Retiree or Eligible Pre-Medicare Dependent (i) did not satisfy the eligibility requirements of Section 2 of this Addendum A; (ii) waived the Reimbursement Allowance and reimbursements; or (iii) was employed or reemployed by the Employer. Upon withdrawal of the waiver of the Reimbursement Allowance and reimbursements, termination of employment by the Employer, or satisfaction of the eligibility requirements of Section 2 of this Addendum A, the Administrator shall credit the HRA Account with an initial Reimbursement Allowance equal to any balance in the prior HRA Account immediately preceding the waiver of coverage, employment or reemployment by the Employer or termination of participation, less any subsequent reimbursements for Qualifying Medical Expenses, in addition to the Reimbursement Allowance the Participant may otherwise be entitled to on a monthly basis.

(e) For purposes of this Subsection 3.2, a Participant's marital status shall be determined as of the first day of the calendar month.

(f) For purposes of this Subsection 3.2, in the event an Eligible Pre-Medicare Dependent is also an Eligible Retiree and participates in the Plan as an Eligible Retiree, then the eligible individual shall elect whether to receive a Reimbursement Allowance as an Eligible Retiree or as an Eligible Pre-Medicare Dependent. No Participant shall have more than one HRA Account in their own name or receive more than one Reimbursement Allowance.

3.3 Loss of Eligibility for Reimbursement Allowance. A Participant shall no longer be eligible to receive the monthly Reimbursement Allowance as set forth in Subsection 3.2 of Addendum A upon the earliest of the following:

(a) The first day of the calendar month following the date the Participant is no longer classified as an Eligible Pre-Medicare Retiree or an Eligible Pre-Medicare Dependent;

(b) The date of the Participant's termination of participation in the Pre-Medicare HRA as set forth in Subsection 2.4 of Addendum A.

SECTION 4.
REIMBURSEMENTS

4.1 Reimbursements for Participants.

(a) Beginning on a Participant's Participation Date, the Pre-Medicare HRA will reimburse a Participant for Qualifying Medical Expenses but only up to the balance in the Participant's HRA Account. A Participant shall be entitled to reimbursement under the Pre-Medicare HRA only for Qualifying Medical Expenses incurred after such individual becomes a Participant in the Pre-Medicare HRA and before the individual's participation in the HPRS Plan has ceased. Notwithstanding the foregoing, Qualifying Medical Expenses incurred after such individual enrolls as a Participant in the Pre-Medicare HRA, but prior to the first date on which a Participant is eligible for a monthly Reimbursement Allowance, are eligible for reimbursement under the Pre-Medicare HRA if they are for accident and health insurance premiums for coverage effective on or after the first date on which the Participant is eligible for a monthly Reimbursement Allowance, regardless of the date such insurance premiums are due.

(b) Except as otherwise provided in this Section 4 and subject to Article IVIV of the HPRS Plan, the reimbursement of Qualifying Medical Expenses shall cease upon the Participant's termination of participation in the Pre-Medicare HRA as set forth in Subsection 2.4 of this Addendum A.

(c) A Participant who continues to meet the requirements of Section 2 of this Addendum A and continues to be a Participant in the Pre-Medicare HRA, but fails to satisfy the requirements and conditions to receive a monthly Reimbursement Allowance for one or more calendar months because the Participant does not have on file with the Administrator a written authorization to permit the direct deposit of reimbursement payments to the account with an appropriate financial institution, and has not received the necessary exemption from direct deposit, as set forth in Subsection 3.2 of this Addendum A, may request reimbursement of Qualifying Medical Expenses pursuant to the provisions of Subsection 4.2 of Addendum A, unless otherwise prohibited under this Section 4.

4.2 Reimbursement of Qualifying Medical Expenses. The Administrator shall reimburse a Participant for Qualifying Medical Expenses, up to the unused amount in the Participant's HRA Account. The amount of any Qualifying Medical Expense not reimbursed as a result of the preceding sentence shall be carried forward and reimbursed at such time as there is a sufficient balance in the Participant's HRA Account. In order to receive the reimbursement, the Participant or authorized representative must submit an application in accordance with Subsection 4.4 of this Addendum A. Reimbursement of Qualifying Medical Expenses from a Participant's HRA Account shall be notionally debited from the Participant's HRA Account as of the date of and in the amounts disbursed from this Pre-Medicare HRA. The Administrator shall reimburse a Participant for the amount of the approved Qualifying Medical Expenses by direct deposit to the Participant's bank account with an appropriate financial institution, as determined by the Administrator, unless such Participant has received from the Administrator the necessary exemption from direct deposit. The Administrator shall reimburse a Participant who has received

from the Administrator the necessary exemption from direct deposit for the amount of the approved Qualifying Medical Expenses by check. Any HRA Account reimbursement payment that is unclaimed by the Participant within one hundred twenty (120) days from the date of the reimbursement payment shall expire and the amount shall be credited back to the HRA Account. If a reimbursement check has expired, the Participant may renew a request for reimbursement by submitting a new application for reimbursement in accordance with Subsection 4.4 of this Addendum A.

4.3 Limitation on Reimbursement of Qualifying Medical Expenses. Notwithstanding any other provision of this Plan, the Administrator may adjust the amount of the Reimbursement Allowance or limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code section 105(h)(5)), without the consent of such person, to the extent the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Any such adjustment shall be made in a nondiscriminatory manner that treats similarly situated persons in substantially the same manner.

4.4 Claims for Reimbursement of Qualifying Medical Expenses.

(a) Timing. Subject to Article III of the HPRS Plan, but no earlier than the Participant's Participation Date, a Participant may apply to the Administrator for reimbursement of Qualifying Medical Expenses by following the reimbursement procedures established by the Third-Party Administrator. The Third-Party Administrator shall reimburse the Participant for expenses that it determines are Qualifying Medical Expenses, up to the balance in the Participant's HRA Account.

(b) Substantiation. The Third-Party Administrator has the discretion to, and shall, verify that all claims for reimbursement constitute Qualifying Medical Expenses. A Participant seeking reimbursement shall be required to comply with any substantiation procedures established by the Third-Party Administrator. A Participant who seeks the reimbursement of Qualifying Medical Expenses must include in the application for reimbursement all of the following information:

(1) The amount, less any amount recovered or expected to be recovered under any insurance arrangement or other plan with respect to the expense, the date, and the nature of the expense with respect to which reimbursement is requested;

(2) The name of the person, provider, insurance carrier, organization or entity to which the expense was or is to be paid;

(3) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant;

(4) In the case of premium reimbursement, the name of the insured, name of insurance carrier, date of coverage, type of coverage, amount of premium, proof of coverage.

Such application shall be accompanied by the documents set forth in the Third-Party Administrator's procedures but shall generally require bills, invoices, insurance provider's explanation of benefits, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional or follow-up documentation which the Administrator or Third-Party Administrator may request.

4.5 Carryover of HRA Account Balance. Except as provided in Subsections 4.6 and 4.7 of this Addendum A, if any balance remains in the Participant's HRA Account at the end of a Plan Year, such balance shall be carried over to the immediately following Plan Year to reimburse the Participant for Qualifying Medical Expenses.

4.6 Loss of Coverage and Forfeiture of HRA Account.

(a) Termination of Participation – Death. Upon termination of participation as set forth in Subsection 2.4(a)(i) of Addendum A due to the death of the Participant, all coverage under the HPRS Plan shall cease unless Participant's surviving Spouse or Dependent continues coverage under the HPRS Plan, if applicable, by electing COBRA continuation coverage pursuant to Article IVIV of the HPRS Plan, or if the Participant's surviving Spouse continues the coverage provided under the Pre-Medicare HRA pursuant to Subsection 4.7(a)(1) of this Addendum A.

(b) Termination of Participation – Reemployment. Upon termination of participation as set forth in Subsection 2.4(a)(ii) of this Addendum A due to employment or reemployment by the Employer, the Participant's coverage under this Pre-Medicare HRA shall cease. Qualified Medical Expenses incurred on or after such date and during the terminated Participant's employment by the Employer shall not be reimbursed. The HRA Account may reimburse claims incurred during any month preceding the Participant's employment or reemployment with the Employer. A terminated Participant shall forfeit the unused amount of the HRA Account ninety (90) days after the date of termination of participation in the Pre-Medicare HRA. In the event such terminated Participant is subsequently eligible to resume participation in the Pre-Medicare HRA or the Medicare HRA, then such Participant's HRA Account shall be reinstated and the forfeited amount shall be restored to the individual's HRA Account. The Participant's eligibility to receive a Reimbursement Allowance shall be governed by Sections 2 and 3 of this Addendum A.

(c) Termination of Participation – Voluntary Termination or Waiver of Reimbursement Allowance and Reimbursements. Upon voluntary termination of participation or waiver of Reimbursement Allowance and reimbursements, as set forth in Subsection 2.4(a)(iii) of this Addendum A, the Participant's coverage under this Pre-Medicare HRA shall cease. Qualifying Medical Expenses incurred on or after such date shall not be reimbursed. The remaining balance in the HRA Account may be used to reimburse claims for Qualifying Medical Expenses incurred during any month preceding the Participant's voluntary termination or waiver of Reimbursement Allowance and reimbursements. A terminated Participant shall forfeit the unused amount of the HRA Account ninety (90) days after the date of termination of participation in the Pre-Medicare HRA. In the event such terminated Participant subsequently withdraws the waiver of Reimbursement Allowance and reimbursements or otherwise resumes participation in the Pre-Medicare HRA or the Medicare

HRA, such Participant's HRA Account shall be reinstated and the forfeited amount shall be restored to the individual's HRA Account, and (i) claims for Qualifying Medical Expenses incurred prior to the effective date of voluntary termination or waiver of Reimbursement Allowance and (ii) claims for Qualifying Medical Expenses incurred after the effective date of the withdrawal of the waiver of Reimbursement Allowance and reimbursements or the date the terminated Participant resumes participation in the Pre-Medicare HRA or the Medicare HRA may be reimbursed. The Participant's eligibility to receive a Reimbursement Allowance after reinstatement shall be governed by Sections 2 and 3 of this Addendum A.

(d) Termination of Participation – Medicare Eligibility. Upon termination of participation in the Pre-Medicare HRA as set forth in Subsection 2.4(b) of this Addendum A due to attaining eligibility for Medicare, the Participant's coverage under the Pre-Medicare HRA shall cease and Qualified Medical Expenses incurred on or after such date shall not be reimbursed by the Pre-Medicare HRA, except as provided in this Subsection 4.6(d). The remaining account balance shall be administered as follows:

(1) If a Participant enrolls in the Medicare HRA effective the first day of the month following termination from the Pre-Medicare HRA due to Medicare Eligibility, the Participant's Reimbursement Allowance under the Medicare HRA shall be deposited in the HRA Account and such deposits shall be combined with any balance in the Participant's HRA Account remaining as of the date of termination from the Pre-Medicare HRA. Such combined balance may be used to reimburse Qualifying Medical Expenses of the Participant and their Dependents incurred on or after the effective date of the Participant's initial enrollment in the Pre-Medicare HRA, and before the Participant's termination as a Participant in the Medicare HRA.

(2) If a terminated Participant does not enroll in the Medicare HRA effective the first month following termination of Participation due to Medicare Eligibility, the Participant's participation in the Plan shall terminate and the balance of the HRA Account shall remain available to reimburse claims of the Participant and Dependents incurred on or after the effective date of the Participant's enrollment in the Pre-Medicare HRA, and before the Participant's termination as a Participant in the Pre-Medicare HRA. Should the terminated Participant subsequently establish participation in the Medicare HRA before the remaining balance in the HRA Account is exhausted, the former Participant's Reimbursement Allowance under the Medicare HRA shall be deposited in the HRA Account and such deposits shall be combined with any balance in the HRA Account remaining as of the date the former Participant enrolls in the Medicare HRA, and such combined balance may be used to reimburse (i) Qualifying Medical Expenses of the Participant and their Dependents incurred on or after the effective date of the Participant's enrollment in the Pre-Medicare HRA, and before the Participant's termination as a Participant in the Pre-Medicare HRA; and (ii) Qualifying Medical Expenses of the Participant and their Dependents incurred on or after the effective date of the Participant's

enrollment in the Medicare HRA, and before the Participant's termination as a Participant in the Medicare HRA.

4.7 Death.

(a) Participant Who Is An Eligible Pre-Medicare Retiree.

(1) Upon the death of a Participant who is an Eligible Pre-Medicare Retiree, the deceased Participant's surviving Spouse may waive COBRA continuation coverage and elect to continue coverage under the Pre-Medicare HRA pursuant to this Subsection 4.7 as alternative coverage to COBRA continuation coverage. Upon the death of a Participant who is an Eligible Pre-Medicare Retiree, if the surviving Spouse waives COBRA continuation coverage and elects to continue coverage under the Pre-Medicare HRA pursuant to this Subsection 4.7 as alternative coverage to COBRA continuation coverage, the Surviving Spouse and such Participant's Dependent(s) shall be eligible to submit claims for: (i) Qualifying Medical Expenses which were incurred by the Participant through the Participant's death, (ii) Qualifying Medical Expenses which are incurred by the surviving Spouse, and (iii) Qualifying Medical Expenses which are incurred by a Dependent, provided the Dependent has waived COBRA continuation coverage. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of Qualifying Medical Expenses must be submitted to the Third-Party Administrator and processed pursuant to Article III of the HPRS Plan and Subsection 4.4 of this Addendum A.

(2) Notwithstanding Subsection 4.7(a)(1) of this Addendum A, an authorized representative (including the deceased Participant's Dependent) of a deceased Participant who was an Eligible Pre-Medicare Retiree may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the Participant's death. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of Qualifying Medical Expenses must be submitted to the Third-Party Administrator and processed pursuant to Article III of the HPRS Plan and Subsection 4.4 of this Addendum A.

(3) The balance in a deceased Participant's HRA Account shall be forfeited twenty-four (24) months after the deceased Participant's death.

(b) Participant Who Is An Eligible Pre-Medicare Dependent. Upon the death of a Participant who is an Eligible Pre-Medicare Dependent, such deceased Participant's

coverage shall cease and any unused amount in the HRA Account on the date of death shall be forfeited. An authorized representative of a deceased Participant who is an Eligible Pre-Medicare Dependent may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the deceased Participant's death. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third-Party Administrator within ninety (90) days of the Participant's death. The balance in a deceased Participant's HRA Account shall be forfeited upon the expiration of the ninety (90) day period following the date of death.

4.8 Coordination of Coverage. Coverage under this Plan is solely intended to reimburse Qualifying Medical Expenses not previously reimbursed elsewhere. To the extent that an otherwise eligible Qualifying Medical Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from the Pre-Medicare HRA. Without limiting the foregoing, if the Participant's Qualifying Medical Expenses are covered by both the Pre-Medicare HRA and by a Health Flexible Spending Account, then this Pre-Medicare HRA shall not be available for reimbursement of such Qualifying Medical Expenses until after amounts available for reimbursement under the Health Flexible Spending Account have been exhausted.

ADDENDUM B

Medicare HRA Provisions

SECTION 1.
PREAMBLE

1.1 Medicare HRA Provisions. This Addendum B, which is hereby incorporated into and made a part of the HPRS Plan, sets forth the terms and conditions of the HPRS Plan applicable to Eligible Medicare Retirees and Eligible Medicare Dependents. Terms and conditions applicable to Eligible Pre-Medicare Retirees and Eligible Pre-Medicare Dependents are set forth in Addendum A to the HPRS Plan. This Addendum B is hereinafter referred to as the "***Medicare HRA***."

1.2 Definitions. Unless otherwise defined in this Addendum B, capitalized terms used in this Addendum B have the same meaning as set forth in Article I of the HPRS Plan.

SECTION 2.
PARTICIPATION AND ELIGIBILITY

2.1 Eligibility for Participation.

(d) Eligible Retirees. Each Eligible Medicare Retiree shall be eligible to become a Participant in the Medicare HRA on the later of: (i) the first date that the Eligible Medicare Retiree is eligible for coverage under Medicare, (ii) the Eligible Medicare Retiree's effective date of retirement benefits as set forth in section 5505-3-01 of the Ohio Administrative Code; or (iii) the Eligible Medicare Retiree's effective date of disability benefits as set forth in section 5505-3-01 of the Ohio Administrative Code ("***Medicare Retiree Eligibility Date***").

(e) Eligible Medicare Dependent. Each Eligible Medicare Dependent shall be eligible to become a Participant in the Medicare HRA on the later of: (i) the first date that the Eligible Medicare Dependent is eligible for coverage under Medicare, or (ii) the date the Eligible Medicare Dependent is eligible to receive health care benefits pursuant to section 5505-7-04 of the Ohio Administrative Code ("***Medicare Eligible Dependent Eligibility Date***"); provided however, that if an Eligible Medicare Dependent has other Health Care Coverage available through a state or federal retirement system, whether or not such other Health Care Coverage is elected, such Eligible Medicare Dependent shall not be eligible to become a Participant in the Medicare HRA. The Medicare Eligible Retiree Eligibility Date and Medicare Eligible Dependent Eligibility Date are collectively referred to hereinafter as "***Eligibility Date***".

2.2 Enrollment in the Medicare HRA and Effective Date. An Eligible Medicare Retiree who satisfies the requirements of Subsection 2.1(a) of this Addendum B and an Eligible Medicare

Dependent who satisfies the requirements of Subsection 2.1(b) of this Addendum B may elect to enroll in the Medicare HRA as a Participant upon: (i) enrollment in Medicare Parts A and B, (ii) enrollment in a Medicare Plan, as defined in Section 1.31 of Article I of the HPRS Plan, which is purchased through the Medicare Connector, and (iii) completion of any enrollment form and enrollment procedures specified by the System ("***Enrollment Requirements***"). Eligible Medicare Retirees and Eligible Medicare Dependents with an Eligibility Date on or before January 1, 2024 must complete the Enrollment Requirements between November 1, 2023 and December 15, 2023. Eligible Medicare Retirees and Eligible Medicare Dependents with an Eligibility Date after January 1, 2024 must enroll in the Medicare HRA during their Initial Enrollment Period. Eligible Medicare Retirees and Eligible Medicare Dependents who do not complete the Enrollment Requirements within the time limits set forth above may not enroll in the Medicare HRA until the next Open Enrollment Period, unless the Eligible Medicare Retiree or Eligible Medicare Dependent qualifies for a Special Enrollment Period as set forth in Subsection 2.2(c) of this Addendum A. The effective date of participation for Eligible Medicare Retirees and Eligible Medicare Dependents as set forth in Subsection 2.2 (a) through (c) below is referred to hereinafter as the ("***Participation Date***").

(a) Effective Date for Eligible Medicare Retirees ("***Participation Date***"). The effective date of participation in the Medicare HRA for an Eligible Medicare Retiree who completes the Enrollment Requirements between November 1, 2023 and December 15, 2023 shall be the first day of the month during which the Eligible Medicare Retiree completes the Enrollment Requirements. The effective date of participation in the Medicare HRA for an Eligible Medicare Retiree who completes the Enrollment Requirements after December 15, 2023 and during their Initial Enrollment Period is the later of (i) the retirement benefits or disability benefits eligibility date, as set forth in OAC 5505-3-01 ("***Eligibility Date***"), or if the Eligibility Date is other than the first day of a month, the first day of the month following the Eligibility Date, or (ii) the first day of the month the Eligible Medicare Retiree's enrollment in Medicare is effective; or (iii) the first day of the first month after the Eligible Medicare Dependent has completed the Enrollment Requirements. The effective date of participation in the Medicare HRA for an Eligible Medicare Retiree who completes the Enrollment Requirements during an Open Enrollment Period is the first day of the Plan Year following the Open Enrollment Period during which the Eligible Medicare Retiree first completes the Enrollment Requirements. If the effective date of the Eligible Medicare Retiree's enrollment in Medicare Part A and Part B are different, the latest effective date shall be used as the criteria in (ii) above.

(b) Effective Date for Eligible Medicare Dependents ("***Participation Date***"). The effective date of participation in the Medicare HRA for an Eligible Medicare Dependent who completes the Enrollment Requirements between November 1, 2023 and December 15, 2023 shall be the first day of the month during which the Eligible Medicare Dependent completes the Enrollment Requirements. The effective date of participation in the Medicare HRA for an Eligible Medicare Dependent who completes the Enrollment Requirements after December 15, 2023 and during their Initial Enrollment Period is the later of (i) the first day of the first month after the death of the deceased Eligible Retiree or deceased Member ("***Eligibility Date***"), or (ii) the first day of the month the Eligible Medicare Dependent's enrollment in Medicare is effective; or (iii) the first day of the first month after the Eligible Medicare Dependent has completed the Enrollment Requirements. The effective date of

participation in the Medicare HRA for an Eligible Medicare Dependent who completes the Enrollment Requirements during an Open Enrollment Period is the first day of the Plan Year following the Open Enrollment Period during which the Eligible Medicare Dependent first completes the Enrollment Requirements. If the effective date of the Eligible Medicare Dependent's enrollment in Medicare Part A and Part B are different, the latest effective date shall be used as the criteria in (ii) above.

(c) Special Enrollment Periods. An Eligible Medicare Retiree or an Eligible Medicare Dependent may enroll during the Plan Year within sixty (60) days of termination of coverage or change in circumstances, as defined by the Internal Revenue Service, and with proof of such termination of coverage or change of circumstances described in section 36B of the Code ("***Special Enrollment Period***"). The effective date of participation in the Medicare HRA ("***Participation Date***") for an Eligible Medicare Retiree or Eligible Medicare Dependent who is entitled to a Special Enrollment Period and who completes the Enrollment Requirements prior to the end of the Special Enrollment Period is the first day of the month after the Eligible Medicare Retiree or Eligible Medicare Dependent completes the Enrollment Requirements.

2.3 Exclusions From Participation. The following persons shall not be eligible to participate in the Medicare HRA: (i) any Eligible Retiree or Eligible Dependent who is ineligible to enroll in coverage under Medicare; (ii) any Eligible Medicare Retiree or Eligible Medicare Dependent who voluntarily terminates enrollment or waives all Reimbursement Allowances and reimbursements; (iii) any Eligible Medicare Retiree or Eligible Medicare Dependent who is employed or re-employed as an Employee of an Employer; (iv) any Eligible Medicare Dependent who has other Health Care Coverage available through a state or federal retirement system, whether or not such other Health Care Coverage is elected; and (v) any recipient of a survivor benefit who does not satisfy the definition of an Eligible Medicare Dependent.

2.4 Termination of Participation. Except as provided in Article IV of the HPRS Plan, a person shall cease to be a Participant on the earlier of (i) the Participant's date of death, (ii) the first day of the calendar month following the date a Participant is not enrolled in both Medicare Part A and Part B or fails to maintain active enrollment in a Medicare Plan purchased through the Connector; (iii) the first day of the calendar month following the Participant's employment or re-employment as an Employee of the Employer, (iv) the first day of the month following a Participant's election to terminate enrollment and waive all Reimbursement Allowances and reimbursements; or (v) the date on which this Plan is terminated by the System. Reimbursements from the Participant's HRA Account after termination of the Participant's participation shall be governed by Section 4 of this Addendum B.

SECTION 3.

FUNDING OF REIMBURSEMENT ALLOWANCE

3.1 System's Source of Funding. The coverage under the Medicare HRA shall be funded by and paid from the operating assets of the System or any such other funding vehicle or mechanism established by the Board on behalf of Eligible Medicare Retirees and Eligible Medicare Dependents. Nothing herein will be construed to require the System or the Administrator

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 System from which any payment under the Medicare HRA may be made. An HRA Account shall be established for each Eligible Medicare Retiree and each Eligible Medicare Dependent who satisfies the requirements of Section 2 of this Addendum B and completes the Enrollment Requirements of Subsection 2.2 of this Addendum B. In no event shall coverage under the Medicare HRA be funded with Participant contributions.

3.2 Reimbursement Allowance.

(a) Eligibility for Reimbursement Allowance. Provided that the Participant continues to meet the requirements of Section 2 of this Addendum B and has on file with the Administrator a written authorization to permit the direct deposit of reimbursement payments to the account with an appropriate financial institution, or has received the necessary exemption from direct deposit, a Participant is eligible for a monthly Reimbursement Allowance provided the following conditions are satisfied on the first day of the calendar month:

(i) In the case of a Participant who is an Eligible Medicare Retiree, such Eligible Medicare Retiree shall receive a Reimbursement Allowance provided such Eligible Medicare Retiree's Medicare Parts A and B coverage is in effect, the Eligible Medicare Retiree purchases a Medicare Plan through the Medicare Connector, and such Medicare Plan coverage is in effect;

(ii) In the case of a Participant who is an Eligible Medicare Dependent, such Eligible Medicare Dependent shall receive a Reimbursement Allowance provided such Eligible Medicare Dependent's Medicare Parts A and B coverage is in effect, the Eligible Medicare Dependent purchases a Medicare Plan through the Medicare Connector, and such Medicare Plan coverage is in effect;

(iii) For purposes of this Subsection 3.2, a Participant's Medicare Parts A and B coverage and Medicare Plan coverage are considered in effect on the first day of the calendar month if the premiums for the corresponding coverage for such calendar month are paid in full on or before the last day of any grace period for such calendar month.

(b) Reimbursement Allowance Amount. The System, in its sole discretion, may provide a monthly Reimbursement Allowance beginning on January 1, 2024 with respect to: (i) each Participant who is an Eligible Medicare Retiree and who satisfies the requirements and conditions of Section 2 of this Addendum B and Subsection 3.2(a)(i) through (iii) as applicable to an Eligible Medicare Retiree, and (ii) each Participant who is an Eligible Medicare Dependent and who satisfies the requirements and conditions of Section 2 of this Addendum B and Subsection 3.2(a)(i) through (iii), as applicable to an Eligible Medicare Dependent. The System by action of its Board shall determine from time to time the amount of the Reimbursement Allowance an Eligible Medicare Retiree is entitled to receive, and the

amount of the basic Reimbursement Allowance shall be the same for all Eligible Medicare Retirees. In addition to the basic Reimbursement Allowance, the System by action of its Board may also provide a supplemental Reimbursement Allowance to Eligible Medicare Retirees who are required to pay a premium for Medicare Part A, to assist the Eligible Medicare Retiree in paying all or part of such premium amount. The supplemental Reimbursement Allowance may, but is not required to vary based upon the Medicare Part A premium each Eligible Medicare Retiree is required to pay; provided however, that the supplemental Reimbursement Allowance may not exceed the amount of Medicare Part A premium the Eligible Medicare Retiree is required to pay. The System by action of its Board shall determine from time to time the amount of Reimbursement Allowance an Eligible Medicare Dependent is entitled to receive, and the amount of Reimbursement Allowance shall be the same for all Eligible Medicare Dependents. In addition to the basic Reimbursement Allowance, the System by action of its Board may also provide a supplemental Reimbursement Allowance to Eligible Medicare Dependents who are required to pay a premium for Medicare Part A, to assist the Eligible Medicare Dependent in paying all or part of such premium amount. The supplemental Reimbursement Allowance may, but is not required to vary based upon the Medicare Part A premium each Eligible Medicare Dependent is required to pay; provided however, that the supplemental Reimbursement Allowance may not exceed the amount of Medicare Part A premium the Eligible Medicare Dependent is required to pay. In addition to the monthly Reimbursement Allowance beginning on January 1, 2024, the System, by action of its Board, may in its sole discretion approve from time to time an ad hoc Reimbursement Allowance for Eligible Medicare Retirees, Eligible Medicare Dependents or both. Upon approval by the Board of the amount of Reimbursement Allowance Eligible Medicare Retirees and Eligible Medicare Dependents are entitled to receive, the System shall notify Eligible Medicare Retirees and Eligible Medicare Dependents of such approved amounts, and such approved amounts shall be automatically incorporated into the Plan. Notification of Eligible Medicare Retirees and Eligible Medicare Dependents of the amount of the Reimbursement Allowance by the System may be by any method reasonably determined by the System to efficiently and effectively provide notice.

(c) Crediting Reimbursement Allowance. For any calendar month that the System has determined to provide a monthly Reimbursement Allowance (or other time period during which an ad hoc Reimbursement Allowance is provided) on behalf of a Participant, the amount of such Reimbursement Allowance will be notionally credited to the Participant's HRA Account at the beginning of such calendar month or other time period. If a Participant fails to maintain on file with the Administrator for one or more months a written authorization to permit the direct deposit of reimbursement payments to an account with an appropriate financial institution, or an exemption from direct deposit, as required under Section 3.2(a), the Reimbursement Allowance for that month or months shall not be credited to the Participant's HRA Account until a written authorization to permit the direct deposit of reimbursement payments to an account with an appropriate financial institution is provided to the System, or an exemption from direct deposit is obtained.

(d) Periodic Ineligibility for a Reimbursement Allowance. If (i) a Participant fails to satisfy the eligibility requirements to receive a Reimbursement Allowance as set forth in Section 2 of this Addendum B and Subsection 3.2(a)(i) through (iii) of this Addendum B for any full calendar month, or (ii) a Participant, Eligible Medicare Retiree or Eligible Medicare

Dependent waives the Reimbursement Allowance and reimbursements for one or more full calendar months, or (iii) a Participant, Eligible Medicare Retiree or Eligible Medicare Dependent is employed or re-employed by the Employer for one or more full calendar months, the Participant, Eligible Medicare Retiree or Eligible Medicare Dependent shall not be entitled to a Reimbursement Allowance for such month(s). If such Participant, Eligible Medicare Retiree or Eligible Medicare Dependent subsequently satisfies the eligibility requirements, withdraws the waiver of a Reimbursement Allowance and reimbursements, or terminates employment by the Employer for a subsequent full calendar month, such Participant, Eligible Medicare Retiree or Eligible Medicare Dependent shall resume receiving a Reimbursement Allowance for each subsequent month thereafter in which the eligibility requirements are satisfied. The Participant, Eligible Medicare Retiree or Eligible Medicare Dependent shall not be entitled to a retroactive Reimbursement Allowance for any calendar month in which such Participant, Eligible Medicare Retiree or Eligible Medicare Dependent (i) did not satisfy the eligibility requirements of Section 2 of this Addendum B and Subsection 3.2(a)(i) through (iii) of this Addendum B; (ii) waived the Reimbursement Allowance and reimbursements; or (iii) was employed or reemployed by the Employer. Upon withdrawal of the waiver of the Reimbursement Allowance and reimbursements, termination of employment by the Employer, or satisfaction of the eligibility requirements of Section 2 of this Addendum B and Subsection 3.2(a)(i) through (iii) of this Addendum B, the Administrator shall credit the HRA Account with an initial Reimbursement Allowance equal to any balance in the prior HRA Account immediately preceding the waiver of coverage, employment or reemployment by the Employer or termination of participation, less any subsequent reimbursements for Qualifying Medical Expenses, in addition to the Reimbursement Allowance the Participant may otherwise be entitled to on a monthly basis.

(e) Marital Status. For purposes of this Subsection 3.2 of Addendum B, a Participant's marital status shall be determined as of the first day of the calendar month.

(f) Dual Eligibility. For purposes of this Subsection 3.2 of Addendum B, in the event an Eligible Medicare Dependent is also an Eligible Retiree and participates in the HPRS Plan as an Eligible Retiree, then the Eligible Medicare Dependent shall elect whether to receive a Reimbursement Allowance as an Eligible Retiree or as an Eligible Medicare Dependent. No Participant shall have more than one HRA Account in their own name or receive more than one Reimbursement Allowance.

3.3 Loss of Eligibility for Reimbursement Allowance. A Participant shall no longer be eligible to receive the monthly Reimbursement Allowance as set forth in Subsection 3.2 of Addendum B upon the earliest of the following:

(a) The first day of the calendar month following the date the Participant is no longer classified as an Eligible Medicare Retiree or an Eligible Medicare Dependent;

(b) The date of the Participant's termination of participation in the Medicare HRA as set forth in Subsection 2.4 of Addendum B;

(c) The first day of the calendar month following the date the Participant is no longer eligible for coverage under Medicare;

(d) The first day of the calendar month following enrollment in other group health coverage that precludes enrollment in a Medicare Plan or coverage under Medicare.

SECTION 4.
REIMBURSEMENTS

4.1 Reimbursements for Participants.

(a) Beginning on the first date on which the Participant is eligible for a monthly Reimbursement Allowance, the Medicare HRA will reimburse a Participant for Qualifying Medical Expenses but only up to the balance in the Participant's HRA Account. A Participant shall be entitled to reimbursement under the Medicare HRA only for Qualifying Medical Expenses incurred after such individual becomes a Participant in the Medicare HRA and before the individual's participation has ceased; provided however that if an individual is a Participant in the Pre-Medicare HRA and timely enrolls in the Medicare HRA upon becoming eligible for Medicare, Qualifying Medical Expenses may be reimbursed as set forth in Subsection 4.6(d) of Addendum A. Notwithstanding the foregoing and except as otherwise permitted above, Qualifying Medical Expenses incurred after an Eligible Medicare Retiree becomes a Participant in the Medicare HRA, but prior to the first date on which a Participant is eligible for a monthly Reimbursement Allowance, are only eligible for reimbursement if they are for Medicare Plan premiums for coverage effective on or after the first date on which the Participant is eligible for a monthly Reimbursement Allowance, regardless of the date such Medicare Plan premiums are due.

(b) Except as otherwise provided in this Section 4 and subject to Article IV of the HPRS Plan, the reimbursement of Qualifying Medical Expenses shall cease upon the Participant's termination of participation in the Plan as set forth in Subsection 2.4 of this Addendum B.

(c) A Participant, who continues to meet the requirements of Section 2 of this Addendum B and continues to be a Participant in the Medicare HRA, but fails to satisfy the requirements and conditions to receive a monthly Reimbursement Allowance for one or more calendar months because the Participant does not have on file with the Administrator a written authorization to permit the direct deposit of reimbursement payments to the account with an appropriate financial institution, and has not received the necessary exemption from direct deposit, as set forth in Subsection 3.2 of Addendum B, may request reimbursement of Qualifying Medical Expenses pursuant to the provisions of this Subsection 4.1, unless otherwise prohibited under this Section 4.

4.2 Reimbursement of Qualifying Medical Expenses. The Administrator shall reimburse a Participant for Qualifying Medical Expenses, up to the unused amount in the Participant's HRA Account. The amount of any Qualifying Medical Expense not reimbursed as a result of the preceding sentence shall be carried forward and reimbursed at such time as there is a sufficient balance in the Participant's HRA Account. In order to receive the reimbursement, the Participant or authorized representative must submit an application in accordance with Subsection 4.4 of this Addendum B. Reimbursement of Qualifying Medical Expenses from a Participant's

HRA Account shall be notionally debited from the Participant's HRA Account as of the date of and in the amounts disbursed from the Medicare HRA. The Administrator shall reimburse a Participant for the amount of the approved Qualifying Medical Expenses by direct deposit to the Participant's account with an appropriate financial institution, as determined by the Administrator, unless such Participant has received from the Administrator the necessary exemption from direct deposit. The Administrator shall reimburse a Participant who has received from the Administrator the necessary exemption from direct deposit for the amount of the approved Qualifying Medical Expenses by check. Any HRA Account reimbursement payment that is unclaimed by the Participant within one hundred twenty (120) days from the date of the reimbursement payment shall expire and the amount credited back to the HRA Account. If a reimbursement check has expired, the Participant may renew a request for reimbursement by submitting a new application for reimbursement in accordance with Subsection 4.4 of this Addendum B.

4.3 Limitation on Reimbursement of Qualifying Medical Expenses. Notwithstanding any other provision of this Plan, the Administrator may adjust the amount of the Reimbursement Allowance or limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of Code section 105(h)(5)), without the consent of such person, to the extent the Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Any such adjustment shall be made in a nondiscriminatory manner that treats similarly situated persons in substantially the same manner.

4.4 Claims for Reimbursement of Qualifying Medical Expenses.

(a) Timing. Subject to Article III of the HPRS Plan, but no earlier than the Participant's Participation Date, a Participant may apply to the Administrator for reimbursement of Qualifying Medical Expenses by following the reimbursement procedures established by the Third-Party Administrator. The Third-Party Administrator shall reimburse the Participant for expenses that it determines are Qualifying Medical Expenses, up to the balance in the Participant's HRA Account.

(b) Substantiation. The Third-Party Administrator has the discretion to, and shall verify that all claims for reimbursement constitute Qualifying Medical Expenses. A Participant seeking reimbursement shall be required to comply with any substantiation procedures established by the Third-Party Administrator. A Participant who seeks the reimbursement of Qualifying Medical Expenses must include in the application for reimbursement all of the following information:

(i) The amount, less any amount recovered or expected to be recovered under any insurance arrangement or other plan with respect to the expense, the date, and the nature of the expense with respect to which reimbursement is requested;

(ii) The name of the person, provider, insurance carrier, organization or entity to which the expense was or is to be paid;

(iii) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant;

(iv) In the case of premium reimbursement, the name of the insured, name of insurance carrier, date of coverage, type of coverage, amount of premium, proof of Medicare coverage.

Such application shall be accompanied by the documents set forth in the Third-Party Administrator's procedures but shall generally require bills, invoices, insurance provider's explanation of benefits, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional or follow-up documentation which the Administrator or Third-Party Administrator may request.

4.5 Carryover of HRA Account Balance. Except as provided in Subsections 4.6 and 4.7 of this Addendum B, if any balance remains in the Participant's HRA Account at the end of a Plan Year, such balance shall be carried over to the immediately following Plan Year to reimburse the Participant for Qualifying Medical Expenses.

4.6 Loss of Coverage and Forfeiture of HRA Account.

(a) Termination of Participation - Death. Upon termination of participation as set forth in Subsection 2.4(i) of Addendum B due to the death of the Participant, all coverage under the HPRS Plan shall cease unless Participant's surviving Spouse or Dependent continues coverage under the Plan, if applicable, by electing COBRA continuation coverage pursuant to Article IV of the HPRS Plan, or if the Participant's surviving Spouse continues the coverage provided under the Plan pursuant to Subsection 4.7(a)(1) of this Addendum B.

(b) Termination of Participation – Medicare Disenrollment. Upon termination of participation as set forth in Subsection 2.4(ii) of this Addendum B due to disenrollment in Medicare Part A, Part B or both, or failure to maintain active enrollment in a Medicare Plan purchased through the Medicare Connector, the Participant's coverage under the HPRS Plan shall cease, and Qualified Medical Expenses incurred on or after such date shall not be reimbursed. The HRA Account may reimburse claims incurred during any month preceding the Participant's termination. A terminated Participant shall forfeit the unused amount of the HRA Account ninety (90) days after the date of termination of participation in the HPRS Plan. In the event such terminated Participant is subsequently eligible to resume participation in the HPRS Plan, then such Participant's HRA Account shall be reinstated and the forfeited amount shall be restored to the individual's HRA Account. The Participant's eligibility to receive a Reimbursement Allowance shall be governed by Sections 2 and 3 of this Addendum B.

(c) Termination of Participation – Reemployment. Upon termination of participation as set forth in Subsection 2.4(iii) of this Addendum B due to employment or reemployment by the Employer, the Participant's coverage under this Medicare HRA shall cease. Qualified Medical Expenses incurred on or after such date and during the terminated Participant's employment with an Employer shall not be reimbursed. The HRA Account may reimburse claims incurred during any month preceding the Participant's employment with an

Employer, and claims incurred during any month succeeding the Participant's employment with the Employer provided the Participant reinstates participation after termination of such employment. A terminated Participant shall forfeit the unused amount of the HRA Account ninety (90) days after the date of termination of participation in the Medicare HRA. In the event such terminated Participant is subsequently eligible to resume participation in the Medicare HRA, then such Participant's HRA Account shall be reinstated and the forfeited amount shall be restored to the individual's HRA Account. The Participant's eligibility to receive a Reimbursement Allowance shall be governed by Sections 2 and 3 of this Addendum B.

(d) Termination of Participation – Voluntary Termination or Waiver of Reimbursement Allowance and Reimbursements. Upon voluntary termination of participation or waiver of Reimbursement Allowance and reimbursements, as set forth in Subsection 2.4(iv) of this Addendum B, the Participant's coverage under this Medicare HRA shall cease. Qualifying Medical Expenses incurred on or after such date shall not be reimbursed. The remaining balance in the HRA Account may be used to reimburse claims for Qualifying Medical Expenses incurred during any month preceding the Participant's voluntary termination or waiver of Reimbursement Allowance and reimbursements. A terminated Participant shall forfeit the unused amount of the HRA Account ninety (90) days after the date of termination of participation in the Medicare HRA. In the event such terminated Participant subsequently withdraws the waiver of Reimbursement Allowance and reimbursements or otherwise resumes participation in the Medicare HRA, such Participant's HRA Account shall be reinstated and the forfeited amount shall be restored to the individual's HRA Account, and (i) claims for Qualifying Medical Expenses incurred prior to the effective date of voluntary termination or waiver of Reimbursement Allowance and (ii) claims for Qualifying Medical Expenses incurred after the effective date of the withdrawal of the waiver of Reimbursement Allowance and reimbursements or the date the terminated Participant resumes participation in the Medicare HRA may be reimbursed. The Participant's eligibility to receive a Reimbursement Allowance after reinstatement shall be governed by Sections 2 and 3 of this Addendum B.

4.7 Death.

(a) Participant Who Is An Eligible Retiree.

(i) Upon the death of a Participant who is an Eligible Medicare Retiree, the deceased Participant's surviving Spouse may waive COBRA continuation coverage and elect to continue coverage under the Plan pursuant to this Subsection 4.7 as alternative coverage to COBRA continuation coverage. Upon the death of a Participant who is an Eligible Medicare Retiree, if the surviving Spouse waives COBRA continuation coverage and elects to continue coverage under the Plan pursuant to this Subsection 4.7 as alternative coverage to COBRA continuation coverage, such Participant's Dependent(s) shall be eligible to submit claims for: (i) Qualifying Medical Expenses which were incurred by the Participant through the Participant's death, (ii) Qualifying Medical Expenses which are incurred by the surviving Spouse, and (iii) Qualifying Medical Expenses which are incurred by a

Dependent, provided the Dependent has waived COBRA continuation coverage. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of Qualifying Medical Expenses must be submitted to the Third-Party Administrator pursuant to Article III of the HPRS Plan and Subsection 4.4 of this Addendum B.

(ii) Notwithstanding Subsection 4.7(a)(1) of this Addendum B, an authorized representative (including the deceased Participant's Dependent) of a deceased Participant who was an Eligible Medicare Retiree may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the Participant's death. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of Qualifying Medical Expenses must be submitted to the Third-Party Administrator pursuant to Article III of the HPRS Plan and Subsection 4.4 of this Addendum B.

(iii) The balance in a deceased Participant's HRA Account shall be forfeited twenty-four (24) months after the deceased Participant's death.

(b) Participant Who Is An Eligible Medicare Dependent. Upon the death of a Participant who is an Eligible Medicare Dependent, such deceased Participant's coverage shall cease and any unused amount in the HRA Account on the date of death shall be forfeited. An authorized representative of a deceased Participant who is an Eligible Medicare Dependent may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the deceased Participant's termination of participation. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's HRA Account determined as of the date of death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third-Party Administrator within ninety (90) days of the Participant's death. The balance in a deceased Participant's HRA Account shall be forfeited upon the expiration of the ninety (90) day period following the date of death.

4.8 Coordination of Coverage. Coverage under this Plan is solely intended to reimburse Qualifying Medical Expenses not previously reimbursed elsewhere. To the extent that an otherwise eligible Qualifying Medical 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 Qualifying Medical Expenses are covered by both the Medicare HRA and by a Health Flexible Spending Account, then the Medicare HRA shall not be available for reimbursement of such Qualifying Medical Expenses until after amounts available for reimbursement under the Health Flexible Spending Account have been exhausted.

HPRS Delegation of Powers Regarding the Administration of the HPRS HRA Plan

RESOLVED, that the Executive Director or any other officer are, and each acting alone is, hereby authorized to do and perform any and all such acts, including execution of any and all documents and certificates, as said individual shall deem necessary or advisable, to carry out the purposes of the foregoing resolutions.

RESOLVED FURTHER, that the Board hereby delegates the power to makes routine amendments to the plan, including but not limited to those required by law, to the Executive Director of HPRS without action of the Board. The board also delegates to the ED those administrative functions which the System is required to perform under the plan document, including but not limited to those set forth in Article VI, except for actions which expressly require Board approval under the plan document, or pursuant to Ohio law, or a policy of the Board.

RESOLVED FURTHER, that the Board hereby delegates the power to administer, review, and decide claims for benefits to Via Benefits as the third-party administrator for the Plan until such time as this delegation is revoked. The Board reserves the rights to modify, revoke, or terminate such delegation at any time in its sole discretion.

RESOLVED FURTHER, that any actions taken by such Executive Director prior to the date of the foregoing resolutions adopted hereby that are within the authority conferred thereby are hereby ratified, confirmed and approved as the acts and deeds of the Board.