GROUP HEALTH BENEFIT PLAN

FOR

RETIREES

OF

THE CITY OF IRVING

As Amended and Restated as of October 1, 2023

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PREAMBLE

City of Irving hereby amends and restates the group health plan known as the Group Health Benefit Plan for Retirees of the City of Irving, last effective October 1, 2017 ("2017 Plan"), by this amendment and restatement effective October 1, 2023 ("Plan"). The terms set forth in this Plan document incorporate by reference the booklet or summary plan description ("SPD") prepared by the Claims Administrator to the extent attributable to Retirees, except to the extent provided in this Plan.

As determined by the Plan Administrator, the terms of the 2017 Plan or its predecessors ("Prior Plans") apply with respect to eligibility for Retirees who became participants under the 2017 Plan before October 1, 2023. Except as expressly provided under this Plan, all claims and benefits incurred or accrued (or otherwise described in or) under this Plan prior to October 1, 2023, shall be determined and administered to the extent determined by the Plan Administrator in accordance with the provisions of the Prior Plans in effect before October 1, 2023. As further determined by the Plan Administrator, effective for all periods on or after October 1, 2023, this Plan is intended to be effective as of such date for all Retirees for all other purposes to the maximum extent permitted by law, including, but not limited to, eligibility, claims, any applicable Employer subsidies and benefits.

Contributions are made by the Employer and Retirees, as applicable. These contributions are based on the amount of premiums and costs necessary to provide the coverage under this Plan. The Coverage Level attributable to contributions on behalf of Retirees is established by the Employer annually. This Plan's benefits may be paid solely from the general assets of the Employer.

The payment of all benefits under this Plan is expressly subject to all the provisions, including amendments, of this Plan document, as well as the terms and conditions of the SPD along with the enrollment materials provided by the Employer to Participants (the terms of which are incorporated herein by reference and will be deemed part of this Plan document).

In the event that the provisions of the SPD or the enrollment materials conflict with any provisions of this Plan document, the Plan Administrator will, in its discretion, interpret the terms and purpose of this Plan so as to resolve any conflict; provided, however, that if the terms of the SPD or the enrollment materials are inconsistent with this Plan or applicable law, the terms of this Plan document will prevail. The terms of this Plan document may not increase the rights of a Participant or his beneficiary to benefits available under any Group Health Benefit Option.

The terms and conditions of the Plan are as follows:

CITY OF IRVING

GROUP HEALTH BENEFIT PLAN

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ARTICLE I

PURPOSE

The purpose of the Plan is to provide Medical Care benefits for Retirees of the Employer and their Dependents who were eligible hereunder. This Plan document sets forth the essential terms and provisions of this Plan. Terms that are capitalized are defined in Article II.

ARTICLE II

DEFINITIONS

The following terms, as used in the Plan, shall have the meaning specified in this Article II, unless a different meaning is clearly required by the context in which it is used:

Any words herein used in the masculine shall be read and construed in the feminine where they would so apply. Words in the singular shall be read and construed as though used in the plural in all cases where they would so apply.

Section 2.01 The term "Attained Age" shall mean the age, in years, of a Participant or Retiree as of the last anniversary of his date of birth.

Section 2.02 The term "Child" shall mean any person who is living in a parent-child relationship with the Covered Retiree and with respect to whom the following requirements are met:

(i) The Covered Retiree has court-appointed responsibilities for the child's medical expenses, or has sole managing conservatorship of the child; and

(ii) The child is:

(a) a natural child,

(b) legally adopted child, including a child for whom the Participant is a party in a court case in which the adoption of the child is sought,

(c) stepchild (where the Covered Retiree or Covered Retiree's spouse has sole managing conservatorship),

(d) foster child,

(e) a child of the Covered Retiree's child ("grandchild") who is the Covered Retiree's dependent for federal income tax purposes at the time the application of coverage of the grandchild is made by the Retiree, or

(f) A child not listed above (1) whose primary residence is the Retiree's household, (2) to whom the Retiree is legal guardian or related by blood or marriage and (3) who is dependent upon the Retiree for more than one-half of his support as defined by the Code.

For purposes of this Plan, the term Dependent will also include those individuals who no longer meet the definition of a Dependent but are beneficiaries under COBRA.

(g) In the case of a child placed for adoption, an adopted child, or a newborn child, the Covered Retiree must verify adoption and birth by legal adoption papers and/or proof of birth to the satisfaction of the Plan Administrator. In

the case of a grandchild, the Covered Retiree must provide documentation showing that the grandchild is a dependent of the Covered Retiree for federal income tax purposes at the time the application for coverage of the grandchild is made.

For purposes of this Section 2.02(ii), the Plan Administrator may request:

(h) whatever legal documentation may be necessary to establish the described relationship of Child as presented to the Plan Administrator; and

(i) whatever other documentation as may be necessary showing that any such Child is a dependent of the Covered Retiree for federal income tax purposes at the time the application for coverage is made and at such other relevant dates and times that the Plan Administrator determines is appropriate.

Section 2.03 The term "Claims Administrator" shall mean the person or persons appointed by the Plan Administrator to determine benefit eligibility and to adjudicate claims under the Plan.

Section 2.04 The term "Code" shall mean the Internal Revenue Code of 1986, as amended.

Section 2.05 The term "Coverage Level(s)" shall mean the selections available to a Retiree, including, but not limited to, Retiree only, Retiree plus children, Retiree plus spouse, or Retiree plus Family.

Section 2.06 The term "Covered Dependent" shall mean each Dependent who is eligible to participate and who participates in the coverage under Section 3.01(ii).

Section 2.07 The term "Covered Retiree" shall mean each Retiree who is eligible to participate and who participates in the coverage under Section 3.01(i).

Section 2.08 The term "Dependent" shall mean any person who was both (a) enrolled and participating in the Employee Medical Plan immediately prior to the one (1) year anniversary of the Retiree's termination of employment from the Employer ("12-Month Period") and (b) is described in (i) or (ii) below.

(i) The legally recognized spouse of a Covered Retiree**;** provided, however, that a spouse who is legally separated or divorced from the Covered Retiree shall not be a Dependent except for purposes of COBRA Continuation Coverage under Section 5.01. In the case of a common law marriage, the spouse shall be considered a spouse under this Plan only if, and on and after the date, the Covered Retiree and common law spouse have obtained a certificate or declaration and registration of informal marriage prior to the Retiree's effective date of retirement.

(ii) A Child of a Covered Retiree who meets one (1) of the following requirements and:

(a) Is under Attained Age twenty-six (26).

(b) Is a child of any age who is medically certified as Disabled and dependent on the parent will not terminate upon reaching the limiting age shown in the SPD's Schedule of Coverage if the child continues to be both:

(1) Disabled, and
(2) Dependent upon the Retiree for more than one-half of his support as defined by the Code.

"Disabled" for purposes of this Section 2.08, means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. A Covered Retiree must submit satisfactory proof of the disability and dependency through the Plan Administrator to the Claim Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a Disabled Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(c) Is either a grandchild of the Covered Retiree or any other child of any age described in Section 2.08(ii)(a) and the Covered Retiree provides documentation showing that such Child is a dependent of the Covered Retiree for federal income tax purposes at the time the application for coverage of any such Child is made.

(d) Is a Child and the Covered Retiree is requested to provide such documentation as the Plan Administrator may determine is appropriate to prove that such Child is a dependent of the Covered Retiree for federal income tax purposes, and the Plan Administrator may request such documentation at the time the application for coverage is made and at such other relevant dates and times as may be determined by the Plan Administrator consistent with procedures established by the Plan Administrator.

(e) Is a child subject to a child support order as described in Section 14.01

Section 2.09 The term "Effective Date" shall mean, for Plan provisions altered by this restatement and except as otherwise provided herein, October 1, 2023.

Section 2.10 The term "Employee Medical Plan" shall mean the Group Health Benefit Plan for Employees of the City of Irving, as in effect on the Effective Date and as may be further amended.

Section 2.11 The term "Employer" shall mean the City of Irving, Texas.

Section 2.12 The term "Enrollment Period" shall, subject to Section 3.01(i)(c), mean a reasonable period of time prior to the beginning of each Plan Year or, the period of time specified under the Plan for open enrollment.

Section 2.13 The term "Family" shall mean a Covered Retiree and his Covered Dependents.

Section 2.14 The term "Group Health Benefit Option" shall mean each of the group health benefit plan coverage options available to Retirees.

Section 2.15 The term "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Section 2.16 The term "Illness(es)" shall include any non-occupational disease; mental, emotional or nervous disorder; and covered pregnancy.

Section 2.17 The term "Injury" or "Injuries" shall mean only non-occupational accidental bodily injury. All Injuries including related conditions and recurrent conditions of such Injuries sustained by a Covered Retiree or Dependent in connection with any accident shall be considered one (1) Injury.

Section 2.18 The term "Medical Care" shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness or Injury provided pursuant to Article VI.

Section 2.19 The term "Medicare" shall mean Title XVIII of the Social Security Act, as amended, and the regulations promulgated thereunder.

Section 2.20 The term "OBRA '93" shall mean the Omnibus Budget Reconciliation Act of 1993.

Section 2.21 "Other Major Medical Coverage" means: (i) group health plan coverage intended to be in compliance with Title XXVII (e.g., Sections 2701 et. seq.) of the Public Health Service Act (as amended by Patient Protection and Affordable Care Act, as amended ("PPACA")), but only to the extent such coverage is a comprehensive major medical plan or program that is not exempt under HIPAA and is not the Employee Medical Plan; (ii) major medical coverage secured by, or on behalf of the Retiree and all Dependents, as applicable, under Medicaid or the applicable state PPACA health insurance marketplace; or (iii) such other medical coverage as the Plan Administrator determines in its sole discretion qualifies as other major medical coverage.

Section 2.22 The term "Participant" shall mean a Covered Retiree or Dependent who meets the requirements for eligibility as set forth in Article III and properly enrolls in the Plan prior to retirement from the City of Irving. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in Article III, except as provided in Article V.

Section 2.23 The term "Plan" shall mean the Group Health Benefit Plan for Retirees of the City of Irving, as amended and restated on the Effective Date and as may be further amended, which provides benefits as described in the SPD, which document is incorporated into and made part of the Plan by reference along with any enrollment materials provided by the Employer to Participants.

Section 2.24 The term "Plan Administrator" shall mean the City of Irving, unless provided otherwise in Article X.

Section 2.25 The term "Plan Year" shall mean October 1 through September 30 each year.

Section 2.26 The term "Qualified Dependent" shall mean a Dependent who is a Participant on the day before a Qualifying Event.

Section 2.27 The term "Retiree" shall mean any former employee of the Employer who before or on the date of termination of employment from the Employer has, as may be determined by the Plan Administrator, both met the eligibility requirements specified for service or disability retirement and timely enrolled in the (a) Texas Municipal Retirement System, (b) the Irving Firemen's Relief and Retirement Fund or (c) the Supplemental Benefit Plan, as and to the extent each such retirement plans or programs have been adopted by the Employer and as each plan or program may be amended (collectively all three plans are the "Pension Plans"). In addition, "Retiree" shall mean a former employee of the Employer who is classified on the Employer's books and records as a "Grandfathered Retiree" under this Plan or any of the Prior Plans for whom the Employer is required by binding agreement that contractually obligates the Employer to provide coverage under this Plan for periods after the covered Grandfathered Retiree has Attained Age sixty-five (65).

ARTICLE III

PARTICIPATION

Section 3.00 Participation: Retirees and their Dependents shall become Participants in the Plan as stated in Section 3.01. The Participant shall make the election of benefits at the specified Group Health Plan Options and Coverage Levels available to such Participant in the form and manner required by the Plan Administrator.

Section 3.01 Eligibility for Medical Benefits for Retirees and their Dependents:

(i) The following provisions of this Section 3.01 apply with respect to eligibility to participate in the Plan by a Retiree, along with such Retiree's Dependents.

(a) Immediate Coverage: To continue coverage from the Employee Medical Plan to this Plan after a "termination of employment" from the Employer, as determined on the books and records of the Employer, the Retiree (1) must timely enroll such Retiree, along with such Retiree's applicable Dependents, who meet eligibility requirements described in Section 3.01(ii) in an allowable Group Health Benefit Option and select the Coverage Levels in the form and manner required by the Plan Administrator or (2) delay coverage before such Retiree's termination of employment with the Employer.

(b) Delayed Coverage: To delay this Plan's coverage, a Retiree must request such delay at the time of such Retiree's termination of employment with the Employer. A Retiree who delays coverage for such Retiree, along with his Dependents, is only allowed one (1) opportunity to enter this Plan at a later date before such Retiree Attains Age sixty-five (65) but only if such Retiree provides proof of continuous Other Major Medical Coverage satisfactory to the Plan Administrator, in its sole discretion, for such Retiree, along with all applicable Dependents, from the Retiree's date of termination of employment with the Employer through the date immediately before the date coverage becomes effective under this Plan.

(c) Proof of Coverage: Proof of coverage will be in the form and manner requested by and determined by the Plan Administrator in its sole discretion. If a Retiree enrolls in this Plan (immediately after the Retiree's termination of employee or later with continuous coverage) and then requests to cancel that coverage, fails to maintain premium payments (or otherwise fails to properly delay such coverage after termination of employment from the Employer in the form and manner specified by the Plan Administrator), such Retiree and any applicable Dependents will not ever be allowed to enroll or re-enroll in this Plan.

(d) Notwithstanding any provision of this Plan to the contrary, Dependents will have no rights of enrollment in this Plan separate and apart from the Retiree, except as provided in Section 3.01(ii)(a) or (b) or Article X.

(e) The provisions of this Section 3.01 above do not and will not apply with respect to a Grandfathered Retiree, as any such Grandfathered Retiree is eligible to participate in this Plan only to the extent and for such period as determined by the Plan Administrator consistent with such agreement between any such Retiree and the Employer finalized prior to October 1, 2023.

(ii) A Dependent of a Retiree shall become eligible in the Plan in accordance with Section 3.01, subject to the following:

(a) In the event of the death of a Participant who is a Retiree, a covered surviving spouse of such Retiree may continue coverage under this Plan until such surviving spouse Attains Age sixty-five (65) by paying the applicable contribution rates for such coverage.

(b) In the event that coverage of a Participant who is a Retiree because the Retiree Attains Age sixty-five (65), a covered spouse of such Retiree may continue coverage under this Plan until such spouse Attains Age sixty-five (65) by paying the applicable contribution rates for such coverage as determined by the Plan Administrator.

(c) A spouse of a Retiree who is a current employee of the Employer cannot participate in the Plan.

(d) Subject to the continuous coverage requirement described in Section 3.01 above and notwithstanding any other provision of this Plan to the contrary, only a Dependent who was enrolled and participating in the Employee Medical Plan immediately prior to the one (1) year anniversary of the Retiree's termination of employment from the Employer (i.e., the "12-Month Period") is eligible to participate and enroll in this Plan.

(1) Subject to any limitations under applicable law, in the event that a Retiree marries after the beginning of the 12-Month Period prior to the Retiree's enrollment in the Plan or after the date of the Retiree's last termination of employment with the Employer, the new spouse is not eligible for coverage under this Plan.

(2) In addition, any Dependent (e.g., a newborn child born, adopted or placed for adoption or spouse married) after the beginning of the 12-Month Period will not be eligible for coverage under this Plan.

(e) Notwithstanding any provision of this Section 3.01 to the contrary, the provisions of this Section 3.01 above do not and will not apply with respect to the Dependents of a Grandfathered Retiree, and any such Grandfathered

Retiree's Dependents are eligible to participate in this Plan only to the extent and for such period as determined by the Plan Administrator consistent with such agreement between any such Retiree and the Employer finalized prior to October 1, 2023.

Section 3.02 Retiree's or Retiree's Dependent's Termination of Participation: Subject to Article V, a Retiree's or Retiree's Dependent's participation under the Plan shall end on the earlier of the following occurrences:

(i) The date the Retiree or Retiree's Dependent (for Dependents who continue coverage in accordance with Section 3.01(ii)) fails to pay required contributions by the due date, which is the first day of each month of coverage, in which case coverage shall terminate on the last date for which the required contributions were paid, as determined by the Plan Administrator, with respect to the Retiree or the Retiree's Dependent, as applicable;

(ii) Except as provided in Section 3.01(ii)(b), the date the Retiree or Dependent dies;

(iii) Except as provided in Section 3.01(ii)(b), the date the Retiree or a dependent spouse of a Retiree Attains Age sixty-five (65);

(iv) The date the Retiree requests that coverage under this Plan terminate, subject to reinstatement only to the extent provided in Section 3.02(viii);

(v) For a Retiree's spouse, the date of divorce or legal separation from the Retiree;

(vi) The date the Retiree loses his status as a Retiree;

(vii) With respect only to a Dependent of a Retiree, the date the Dependent of the Retiree is no longer eligible under the Plan;

(viii) The date the Retiree returns to work for the Employer as an employee of the Employer after enrolling and participating in this Plan; provided, however, that a Retiree may again become a Covered Retiree under this Plan upon such rehired Retiree's subsequent termination of employment with the Employer, but only if such Retiree's employment with the Employer does not (and will not) impact any Pension Plan benefits received by any such Retiree after his initial participation in this Plan as a Retiree;

(ix) In the event that the Plan Administrator determines that the Retiree or Dependent misrepresented a claim for expenses or a fact relating to eligibility for participation or benefits or failed to disclose a material fact relating to eligibility or a claim for expenses, the date the Retiree or Dependent misrepresented such fact, subject to applicable law; or

(x) The date the Plan terminates.

(xi) Notwithstanding any provision of Section 3.02(i) to the contrary, the provisions of Section 3.02(i) above do not and will not apply with respect to a Grandfathered Retiree, the Dependents of a Grandfathered Retiree. Any such Grandfathered Retiree's participation in this Plan, along with the participation of such Grandfathered Retiree's Dependents, shall end on the date determined by the Plan Administrator consistent with such agreement between any such Retiree and the Employer finalized prior to October 1, 2023.

ARTICLE IV

CONTRIBUTIONS

Section 4.01 Retiree Contributions: Retirees (and any surviving spouse of a Retiree who becomes covered under the Plan in accordance with Section 3.01(ii)(b) after the death of the Retiree) participating in the Plan shall make contributions in an amount as determined by the Plan Administrator and communicated to the Retirees, including, but not limited to, considering any wellness or other credits, if any that might be provided to the Retirees, along with any contributions applicable to any Dependents.

Section 4.02 Employer Contributions: Employer contributions to provide medical benefits are different depending upon the time a Retiree is hired or retires.

(i) Retirees Including Pre-2011 Retirees: The Employer expects to contribute the amount required to provide medical benefits under the Plan for Retirees (and their Dependents) who had retired before 2011 under the Prior Plans ("Pre-2011 Retiree") in an amount equal to the amount or level of such contributions which were provided or otherwise established under the Prior Plans for such Retiree as determined by the Plan Administrator; provided, however, that a Pre-2011 Retiree shall in no event receive contributions less than the amount set forth in Section 4.02(ii).

(ii) Post-2010 Retirees: Effective for the Plan Year beginning October 1, 2023, and except as provided in Section 4.02(i), the fixed monthly subsidy for medical benefits for Retirees provided by the Employer will be based on the sum of both the Attained Age and the number of whole years of continuous service the Retiree served and earned under the applicable Pension Plan under which the Retiree last provided services to the Employer, as may be determined by the Employer and communicated to the Retiree (but in no event may any such premium reduction credit or subsidy exceed the cost of coverage paid by Employer under this Plan), which shall be the following until or unless a different amount is communicated by the Employer to the Retiree:

(a) Rule of 60. Retirees who meet the Rule of 60 will receive a premium reduction credit in the amount of one-hundred seventy-five dollars ($175) per month. "Rule of 60" means the sum of (i) and (ii) equaling or exceeding 60 where: (i) equals the Attained Age; and (ii) equals the years of continuous service as determined by the applicable Pension Plan.

(b) Rule of 70. Retirees who meet the Rule of 70 will receive a premium reduction credit in the amount of four hundred dollars ($400) per month. "Rule of 70" means the sum of (i) and (ii) equaling or exceeding 70 where: (i) equals the Attained Age; and (ii) equals the years of continuous service as determined by the applicable Pension Plan.

(c) Rule of 80. Retirees who meet the Rule of 80 will receive a premium reduction credit in the amount of seven hundred ($700) per month. "Rule of 80" means the sum of (i) and (ii) equaling or exceeding 80 where: (i) equals the Attained Age; and (ii) equals the years of continuous service as determined by the applicable Pension Plan.

(d) Rule of 90. Retirees who meet the Rule of 90 will receive a premium reduction credit in the amount of $700 per month. Effective on October 1, 2024, Retirees who meet the Rule of 90 will receive a premium reduction credit in the amount of one thousand dollars ($1,000) per month. "Rule of 90" means the sum of (i) and (ii) equaling or exceeding 90 where: (i) equals the Attained Age; and (ii) equals the years of continuous service as determined by the applicable Pension Plan.

For Plan Years beginning after October 1, 2023, the Employer may modify any or all of the amounts set forth above with respect to, or related to, one or more Retirees and make available to each Participant who participates in this Plan a subsidy in an amount to be determined by the Employer prior to the beginning of each Plan Year, but only if such subsidy is approved by the Employer on a Plan Year by Plan Year basis. The Employer will communicate to Retirees the amount and timing of any such approved subsidy prior to first day of the Plan Year to which such subsidy applies. The subsidy provided by the Employer is limited to the premium amount paid by the Retiree. In no event shall any Retiree receive a rebate from the Employer due to any premium reduction credit under this Section 4.02.

Retirees will not have had a break in active years of continuous service for any period during which they are on a leave of absence authorized by the Employer, provided they return to work at the end of the leave of absence.

Section 4.03 Sources of Funds for Benefit Payments and Plan Administration Expenses: Benefit payments and Plan administration expenses and fees (including claims administration expenses) shall be paid from the following sources:

(i) The general assets of the Employer;

(ii) Contributions made pursuant to Section 4.01 and Section 4.02 by Covered Retirees and any surviving spouses of Retirees that are not deposited in a plan-related trust;

(iii) Insurance contracts, the premiums for which are paid from (i), (ii) above or (iv) below; and

(iv) Only to the extent that the Employer determines that the obligations under this Plan or any Prior Plans, as applicable, are to be funded under the City of Irving, Texas trust fund established under the Voluntary Employees' Beneficiary Association Trust Agreement.

In no event shall the Employer (or any of its agents), the Plan Administrator, the City Manager, the City Council or any other party be responsible for payment of benefits except to the extent funded by the general fund of the Employer.

ARTICLE V

SPECIAL PROVISIONS FOR CONTINUATION OF COVERAGE

Coverage that would otherwise terminate under the Employee Medical Plan may be continued due to eligibility for "COBRA Continuation Coverage" (as defined below in this Article V) to the extent provided under the Employee Medical Plan and shall not be subject to terms of this Plan, except with respect to certain Qualified Dependents to the extent required by law or as otherwise determined by the Plan Administrator. Regardless, COBRA continuation provisions are generally set forth below, subject to any modifications or adjustments contained in the Employee Medical Plan.

Section 5.01 COBRA Continuation Coverage: Shall be continued based upon the following circumstances:

(i) COBRA Continuation Coverage for Dependents: A Qualified Dependent may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of a Qualifying Event. Coverage under this Section 5.01(i) may not continue beyond:

(a) The date on which the Employer ceases to maintain a group health plan;

(b) The last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 5.01(v);

(c) The date the Covered Retiree first becomes entitled to Medicare after the date of his election of COBRA Continuation Coverage in accordance with this Article V; or

(d) The date the Covered Retiree first becomes covered under another group health plan after the date of his election of COBRA Continuation Coverage in accordance with this Article V or new employer plan.

(ii) Period of COBRA Continuation Coverage for Dependents: If a Qualified Dependent elects COBRA Continuation Coverage under the Plan as a result of the Loss of Dependent Status may continue for up to thirty-six (36) months. COBRA Continuation Coverage under this Section 5.01(ii) may not continue beyond:

(a) The last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 5.01(iii);

(b) The date the Qualified Dependent first becomes entitled to Medicare after the date of his election of COBRA Continuation Coverage in accordance with this Article V;

(c) The date on which the Employer ceases to maintain a group health plan; or

(d) The date the Qualified Dependent first becomes covered under another group health plan after the date of his election of COBRA Continuation Coverage in accordance with this Article V or new employer plan.

(iii) Contribution Requirement for COBRA Continuation Coverage: Covered Qualified Retiree Dependents who elect COBRA Continuation Coverage as a result of one (1) of the Qualifying Events specified in Section 5.01 will be required to pay Continuation Coverage Payments.

Covered Qualified Retiree Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Covered Qualified Retiree Dependent has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Payment for the first month's payment and the cost for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Retiree Dependent actually elects COBRA Continuation Coverage. The Covered Qualified Retiree Dependents shall have a thirty (30) day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the thirty (30) day grace period; however, if the grace period ends on a Saturday, Sunday, or holiday, the grace period extends until the next business day. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of COBRA premiums as set out in this Section 5.01(iii).

(iv) Limitation on Participant's Rights to COBRA Continuation Coverage:

(a) If a Qualified Dependent loses, or will lose medical coverage under the Plan as a result of divorce or ceasing to be a Dependent, the Covered Retiree or the Qualified Dependent is responsible for notifying the Plan Administrator within sixty (60) days of the later of (A) the date of the divorce or loss of Dependent status or (B) the date the Qualified Dependent would lose coverage on account of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Qualified Dependent's rights to COBRA Continuation Coverage under this Article V.

(b) A Participant must complete and return the required COBRA election materials within sixty (60) days from the later of (i) loss of coverage, or (ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage. Failure to enroll for COBRA Continuation Coverage during this sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article V. An affirmative election of COBRA Continuation Coverage by a Covered Retiree's spouse shall be deemed to be an election for that Covered Retiree's Qualified Dependents who would otherwise lose coverage under the Plan.

(v) Subsequent Qualifying Event: If a second Qualifying Event occurs during an eighteen (18) month extension explained above, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event. In the event a Qualified Dependent loses coverage due to a Qualifying Event, then after such date the Covered Employee becomes entitled to Medicare, the Qualified Dependent shall have available up to thirty-six (36) months of coverage measured from the date of the Qualifying Event which causes the loss of coverage.

(vi) Extension of COBRA Continuation Period for Disabled Covered Retirees and Qualified Dependents: The period of continuation shall be extended to twenty-nine (29) months in total (measured from the date of the Qualifying Event) in the event a Covered Qualified Dependent has a COBRA Disability, provided that the Covered Employee or Qualified Dependent provides evidence to the Plan Administrator of such COBRA Disability prior to the expiration of the initial eighteen (18) months of COBRA Continuation Coverage. In such event, the Employer may charge the individual up to 150% of the COBRA cost of the coverage. Non-disabled members of the Family of a Covered Employee or Qualified Dependent entitled to the disability extension provided under this Section 5.01(vi) are also entitled to the 29-month extended period of coverage.

(vii) Medicare Entitlement: For purposes of this Article V, Medicare entitlement, including Medicare entitlement due to end stage renal disease ("ESRD"), is a COBRA terminating event if it occurs after the COBRA qualifying event.

(viii) COBRA Continuation Coverage for Retiree Dependents: A Qualified Retiree Dependent shall have all continuation rights required by COBRA. To the extent this Plan does not specify COBRA rights for Retirees in accordance with Code Section 4980B, the Employer shall administer such COBRA Continuation Coverage rights in accordance with Code Section 4980B. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 5.01(viii).

Notwithstanding the foregoing, to the extent permitted by applicable law, a Retiree who elects to continue coverage under the Employee Health Plan, and the spouse and/or Dependents who elect to continue coverage under the Employee Health Plan, shall be required to waive their COBRA Continuation Coverage rights, if any, under this Plan and shall thereafter no longer have such rights.

Except as determined by the Plan Administrator consistent with applicable law, the Plan is intended to be exempt from the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, regardless of whether under Texas law or under federal medical care continuation provisions of law that may apply to governmental entities ("COBRA Continuation Coverage").

ARTICLE VI

BENEFITS

Section 6.01 Medical Benefits: Medical benefits under this Plan will be provided as set forth in the SPD and the applicable enrollment materials provided by the Employer.

Section 6.02 Medical Benefits Limitations and Exclusions: The medical benefit limitations and exclusions are described in the SPD Section titled "*Medical Limitations and Exclusions*," as may be amended or successors to such provisions.

Section 6.03 Wellness Program Benefits: The Employer maintains a Welfare Program, known as the City of Irving Wellness Program, as it may be amended (hereinafter the "Wellness Program") that may, but is not required, to cover in whole, or in part, Covered Retirees and Covered Dependents. The Wellness Program is part of the Employer's other benefits offered under this Plan. The terms of the Wellness Program are set forth in the following benefit pamphlets (i) the Employer's enrollment benefits guide, (ii) any successor pamphlets, and (iii) such other documents or enrollment materials, if any, provided by the Employer and Claims Administrator, describing the Wellness Program's benefits ("Pamphlets").

(i) The Wellness Program is or may in the future be comprised of participatory, activity-only and outcome-based components. Covered Retirees may qualify for an incentive or reward under the Wellness Program at least one (1) time per year. The Wellness Program is reasonably designed to promote health and prevent disease.

(ii) If Wellness Program benefits are provided during a Plan Year, such benefits will be described in the Wellness Program Pamphlets and communicated to Retirees.

(iii) Individuals are not required to participate in any particular component of the Wellness Program.

(iv) The purpose of this Section 6.03 and the Wellness Program Pamphlets, if any, is to set forth the essential terms and provisions of the Wellness Program, if any may be established, and to provide Covered Retirees with the benefits described herein and in the Wellness Program Pamphlets, which are incorporated into this Plan by reference, but only to the extent applicable.

(v) Limitations on eligibility will be described in the Wellness Program Pamphlets. Participation in the Wellness Program for any Covered Retiree and Covered Dependents does not impact "eligibility" for (or other terms of) this Plan.

(vi) The Pamphlets may, in the future, be revised to include additional covered individuals; provided, however that Retirees will be notified in the preceding Plan Year in which any changes in eligibility or benefits under the Wellness Program occur.

(vii) Participation in the Wellness Program is voluntary, but to receive benefits under the Wellness Program, Covered Retirees must satisfy the requirements of the

Wellness Program. These requirements will be outlined in the Pamphlets and/or annual wellness informational packet provided to all eligible Covered Retirees. As discussed in the Pamphlets and/or annual wellness informational packet, the requirements to qualify for a reward under the Wellness Program may be satisfied in many different ways, regardless of health status. The wellness information outlined will include program requirements, ways to meet requirements, program dates and deadlines, and any supplemental information regarding the Wellness Program.

(viii) Participatory Programs: The Wellness Program described in the aforementioned Wellness Program Pamphlets includes (or may in the future include) elements that may be considered participatory. Participatory wellness programs must be made available to all similarly situated individuals, regardless of health status. Under a participatory wellness program, a Covered Retiree is required to engage in an activity that is not related to a health factor (with no specific outcome required) to receive an incentive or a reward under the Wellness Program. Upon satisfying the Wellness Program's standard(s), the Covered Retiree will receive an incentive, or a reward as described in the Pamphlets.

(ix) Activity-Only Programs: The Wellness Program described in the aforementioned Wellness Program Pamphlets includes (or may in the future include) elements that may be considered activity-only wellness programs. An activity-only wellness program requires a Covered Retiree to complete or to perform an activity related to a health factor in order to obtain the offered reward or incentive, but it does not require a Covered Retiree to attain any specific health outcome to receive the reward. The Employer will provide safeguards to ensure individuals are given a reasonable opportunity to qualify for the incentive or reward (i.e., a reasonable alternative standard), or waive the condition for obtaining the reward, thus making the full reward available to all similarly situated individuals. Under an activity-only wellness program, it is permissible for a plan or issuer to seek verification, such as a statement from the individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard in an activity-only wellness program, if reasonable under the circumstances. If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness or waive the condition for obtaining the reward. The Employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

(x) Outcome-Based Programs: The Wellness Program described in the aforementioned Wellness Program Pamphlets includes (or may in the future include) elements that may be considered outcome-based. An outcome-based wellness program requires a Covered Retiree to attain or maintain a specific health

outcome related to a health factor in order to obtain the offered reward or incentive. The Employer is aware that some Covered Retirees may be unable to meet the initial standard in an outcome-based wellness program based on the measurement, test, or screening used under the outcome-based wellness program. The Employer will provide a reasonable opportunity to any individual who does not meet the initial standard based on the measurement, test, or screening to qualify for the incentive or reward (i.e., a reasonable alternative standard), or waive the condition for obtaining the reward, thus making the full reward available to all similarly situated individuals. Under an outcome-based wellness program, a plan or issuer may not seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy the standard as a condition of providing a reasonable alternative standard. If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness or waive the condition for obtaining the reward. The Employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

(xi) Maximum Reward or Incentive Caps: The maximum permissible reward (or penalty) under the Wellness Program is capped. Specifically, the maximum rewards (or penalties) for the components of the Wellness Program that may be classified (i) activity-only wellness programs that are offered in connection with the Employer group health plan, and/or (ii) outcome-based wellness programs that are offered in connection with the Employer group health plan may not total up to more than 30% of the total cost of coverage (including both Employer and Retiree contributions). In addition, the maximum permissible reward (or penalty) is 50% of the total cost of coverage for wellness program incentives designed to prevent or reduce tobacco use.

(xii) Voluntariness: The Plan Administrator will in good faith administer the Wellness Program to ensure that the maximum reward or incentive offered under the Wellness Program for portions of the Wellness Program that contain disability-related inquiries and/or medical examination(s) are set at a level wherein the participation in the Wellness Program will be voluntary. To the extent the EEOC or other applicable governmental entity establishes a specific dollar or percentage threshold to determine whether a particular Wellness Program is voluntary, the Wellness Program will comply with such threshold at such time it becomes effective and applicable.

(xiii) Termination of Benefits: Termination of participation in the Wellness Program is described in the Wellness Program Pamphlets or on the date the Covered Retiree is no longer eligible under any of the medical Welfare Programs. An individual's coverage under the Wellness Program may be terminated by the Plan Administrator

for cause. "Cause" will be determined by the Plan Administrator in its sole discretion and will disqualify the Covered Retiree's eligibility for the premium discount or other applicable rewards.

(xiv) Benefits: Benefits under the Wellness Program are described in the Wellness Program Pamphlets. Nothing in this Plan shall require the Employer to establish or provide a Wellness Program to any Participant.

(xv) Plan Provisions that Apply to the Wellness Program: All Plan funding, administrative, technical, and legal provisions apply to the Wellness Program.

(xvi) GINA: Notwithstanding anything in this Plan and Wellness Program to the contrary and only if applicable, the Wellness Program will comply with GINA. To ensure compliance GINA, if the Wellness Program now or in the future includes an online personal health assessment, and a Covered Retiree completes the Employer's online personal health assessment, the Covered Retiree will still receive credit for completing the assessment if the Covered Retiree does not answer the questions on family medical history and other genetic information. Any genetic information disclosed in connection with the Wellness Program may be provided to the Employer only in the aggregate form. In addition, and only if applicable, the Wellness Program will comply with the EEOC regulations pertaining to wellness programs in which a Spouse may participate.

ARTICLE VII

COORDINATION OF BENEFITS WITH OTHER PLANS

Section 7.01 Coordinating Benefits: If a Participant has coverage under this Plan as well as coverage from another source, benefits that are received through this Plan shall be coordinated with the benefits available under the plan containing the Participant's other source of benefits. This coordination of benefits provision shall apply to all benefits provided under this Plan as described in the SPD Section "*Coordination of Benefits*"; provided however, that with respect to benefits under Medicare, which coordinating benefits are described in Section 7.02.

Section 7.02 Special Provisions for Participants Eligible for Medicare: The following provisions apply to determine the primary payer of benefits when Retirees are covered under this Plan and are eligible to be covered under the hospital insurance portion of Medicare.

(i) Unless determined otherwise, this Plan shall be primary for Participants who have End Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). The Plan shall be primary for thirty (30) months beginning on the date the Participant becomes eligible for Medicare benefits due to ESRD, unless the Participant was already entitled to Medicare benefits on the basis of age or disability when he or she became eligible on the basis of ESRD.

(ii) For purposes of this Section 7.02 and subject to regulations promulgated by the Centers for Medicare and Medicaid Services (CMS), "Active Employee" shall be given the same meaning as specified under OBRA '93 as it relates to both a non-disabled employee and primary and secondary payments for individuals who are considered disabled individuals.

(iii) For purposes of this Section 7.02 only, the term "Participant" shall not include any Retiree who is Attained Age sixty-five (65) or older.

ARTICLE VIII

CLAIMS PAYMENT PROVISIONS

Section 8.01 Payment of Benefits: Benefits payable shall be paid to the Covered Retiree upon receipt by the Claims Administrator of written proof that the Participant had an eligible expense as described in the SPD. The Plan shall pay benefits directly to the Covered Retiree unless the Covered Retiree requests otherwise, provided that such request must be made not later than the time the request for payment of benefits is filed. The assignment of benefits by a Covered Retiree will not be binding upon the Plan without its written consent.

Section 8.02 Payment to Legal Representative: In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant, any such payment under the Plan may be made to such representative and such payment will discharge any liability under the Plan.

Section 8.03 Procedure for Filing Claims: The Claims Administrator shall promulgate guidelines for efficient filing of claims. Such guidelines shall be furnished to each Participant as further described in SPD Section "*Claim Filing and Appeals Procedures*" (as amended), which procedures are incorporated into and made part of the Plan by reference; provided; however, that there are no external review procedures for Participants.

Section 8.04 Exhaustion of Administrative Remedies: Except as expressly provided otherwise in the SPD, no action at law or in equity may be brought to recover under this Plan until all administrative remedies have been exhausted. If a claimant fails to file a request for review in accordance with the procedures outlined herein, such claimant shall have no rights of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section 8.05 Action for Recovery: Except as any such date is expressly provided in the SPD, no action at law or in equity may be brought for recovery under this Plan after three (3) years from the time written proof of a claim is required to be furnished

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.01 Right of Recovery: If the Plan has made an erroneous or excess payment to any Participant, the Plan Administrator shall be entitled to recover such excess from the Participant to whom such payments were made. The recovery of such overpayment may be made by charging the Participant directly or by offsetting the amount of any other benefit or amount payable to the Participant by the amount of the overpayment under the Plan.

Section 9.02 Reimbursement Agreement; Right of Subrogation:

(a) If a Participant receives or becomes eligible to receive any benefit under the Plan ("Reimbursable Benefit") arising from an accident, injury, or illness for which the Participant has, may have, or has asserted any claim or rights to recovery against a third party or parties, then any payment by this Plan with respect to such Reimbursable Benefit shall be made on the condition that this Plan will be reimbursed by the Participant, to the extent of any amount or amounts received or receivable from or with respect to the third party or parties, whether by way of suit, judgment, settlement, compromise, or otherwise and without regard to how the amount received from the third party or parties is characterized. The Plan's reimbursement right has first priority with respect to payment on any claim against a third party before the Participant receives payment from the third party. The Plan's first priority right is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, which assert a right to payment from funds a Participant may recover from a third party.

(b) The "make whole doctrine" arising under federal common law and under state law does not apply to the Plan's reimbursement or subrogation rights. The Plan retains its reimbursement and subrogation rights described herein regardless of whether the Participant's receipt of payment from other sources fully reimburses the Participant or whether the Participant has been "made whole." The Plan's reimbursement and subrogation rights apply to the full amount the Participant receives (unreduced by attorney's fees and other expenses). The Plan does not share in the cost of the Participant's recovery. These rights apply to full and partial settlements, judgments or other recoveries paid or payable to the Participant no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to assist any Participant to pursue a claim for damage or personal injuries, or pay any associated costs, including attorney's fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

(c) The Participant may be obligated to sign a reimbursement agreement, as prescribed by the Plan Administrator, before any Reimbursable Benefits are paid from this Plan. If Reimbursable Benefits are paid with respect to a Participant who is a minor or is mentally incapacitated, the Plan Administrator may require the Covered Retiree to execute a reimbursement agreement on such Participant's behalf, and all other provisions of this Section 9.02 apply to the parents or guardians of such minor or incapacitated Participants.

(d) A Participant must agree to cooperate with the Plan and its agents in a timely manner to protect the legal and equitable right of the Plan to subrogation and reimbursement including, complying with the terms of this Section 9.02, providing relevant information requested, signing and delivering documents at the request of the Plan, notifying the Plan, in writing, of any potential legal claim(s) the Participant may have against any third parties for acts which caused benefits to be paid under the Plan, responding to requests for information about any accident or injuries, appearing at medical examinations and legal proceedings, such as depositions or hearings, and obtaining the Plan's consent before releasing any party from liability or payment or medical expenses.

(e) The Plan shall be subrogated to all claims, demands, actions and rights of recovery of the Participant against a third party or parties to the extent of any and all payments made by the Plan with respect to Reimbursable Benefits, and the reimbursement agreement shall so provide. Upon request of the Plan, the Participant may be required to assign to the Plan all rights of recovery against third parties to the extent benefits under the Plan have been provided with respect to the actions of a third party.

(f) If a Participant receives payment as part of a settlement or judgment from any third party as a result of any action by the third party and the Plan alleges some or all of those funds are due and owed to it, the Participant agrees to hold those settlement funds in trust, either in a separate bank account in the Participant's name or in the trust account of the Participant's attorney. The Participant agrees to serve as a trustee over those funds to the extent benefits under the Plan have been paid.

(g) The Plan has the right to recover attorney's fees and costs incurred by the Plan in order to collect third party settlement funds held by a Participant.

(h) Participants may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval, and the Plan's rights will not be reduced due to the negligence of a Participant.

(i) The Plan may, at its option, take necessary action to assert its rights under this Section 9.02, including filing suit in the name of the Participant, which

does not obligate the Plan in any way to pay any part of the recovery to the Participant.

(j) In case of the wrongful death or survival claim of the Participant, the provisions of this Section 9.02 apply to the Participant's estate, the personal representative of the estate, and any heirs or beneficiaries.

(k) A Participant's failure to cooperate with the Plan or its agents under this Section 9.02 is considered a breach of contract. As such, the Plan has the right to terminate benefits under the Plan, deny future benefits under the Plan, take legal action against a Participant, and/or set off from any future benefits the value of benefits the Plan has paid relating to any action caused by a third party to the extent not recovered by the Plan due to the Participant's or the Participant's representative not cooperating with the Plan.

(l) If a third party causes a Participant to suffer an accident, illness, or injury while covered under the Plan, the provisions of this Section 9.02 continue to apply, even if the Participant is no longer covered under the Plan.

(m) The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Section 9.03 Verification: The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as a Participant. If the Participant does not supply the requested information or provide a release for such information, such Participant shall not be entitled to benefits under the Plan.

Section 9.04 Limitation of Rights: Nothing appearing in or done pursuant to the Plan shall be held or construed:

(i) To give any person any legal or equitable right against the Employer, the Plan Administrator, or any other committee or person connected therewith, except as expressly provided herein or as provided by law; or (ii) To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided herein.

Section 9.05 State of Jurisdiction: To the extent not preempted by federal law, the provisions of the Plan shall be construed, enforced and administered according to the laws of the State of Texas.

Section 9.06 Severability: If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

Section 9.07 Captions: The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

Section 9.08 Entire Plan: This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

Section 9.09 Venue: By electing to participate in the Plan, all Participants consent and agree that the only location for filing or trying a lawsuit which determines the liability, amount of benefits and/or amount of damages under the Plan shall be in Dallas County, Texas. If a lawsuit is filed or tried outside of Dallas County, Texas, excluding the appellate process, to determine liability, benefits or damages against the Plan, then the Plan shall have no obligation to or on behalf of a Participant concerning the claims in said lawsuit.

Section 9.10 Unclaimed Funds: Any amount due and payable to a Participant shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant to whom such payment is due. Such forfeited amounts shall be applied toward Employer contributions to the Plan. However, if a claim is later made by the participant or other person, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable in accordance with the terms of the Plan, subject to any time limitations for submitting claims. The Plan Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

ARTICLE X

DUTIES AND POWERS OF THE PLAN ADMINISTRATOR

Section 10.01 Appointment of Plan Administrator: The Employer shall be the Plan Administrator unless another Plan Administrator is appointed by the City Manager for the City of Irving ("City Manager") to administer the Plan and keep records of proceedings and claims. Any Plan Administrator who is appointed by the City Manager will serve until resignation or dismissal by the City Manager, and any vacancy or vacancies shall be filled in the same manner as the original appointments. The City Manager may dismiss any person or persons serving as Plan Administrator at any time with or without cause. No compensation will be paid to the Plan Administrator for service as such, but any reasonable expenses incurred pursuant to such service will be reimbursed by the Employer. In the event the City Manager chooses to appoint more than one (1) person to act as Plan Administrator, a majority vote of such persons shall be necessary for the transaction of business. In the event only two (2) persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties. All usual and reasonable expenses of the Plan Administrator may be paid in whole or in part by the Employer and any expenses not paid by the Employer shall not be the responsibility of the Plan Administrator.

Section 10.02 Powers of Plan Administrator: Subject to the limitations of the Plan, the Plan Administrator will from time-to-time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of the Employer with respect to any and all factual matters dealing with the employment of a Retiree. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have complete and final discretionary authority to construe and interpret the Plan and determine all questions arising in the administration, interpretation, and application of the Plan and its provisions (including questions of whether a claim is a reimbursable claim under this Plan). Without limitation, such decisions by the Plan Administrator as to the determination of all related or non-related questions and matters that arise under the Plan shall be final, conclusive and binding, and there shall be no *de novo* review of any such decision by any court. Any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion. Without limitation, all determinations, decisions and exercises of power under this Plan by the Employer or the Plan Administrator or their respective delegates shall be made by any such person in their sole and absolute discretion and to the maximum extent provided by law and as otherwise provided in this Section 10.02, as if each and every such person had the powers delegated to the Plan Administrator.

Section 10.03 Outside Assistance: The Plan Administrator may employ such counsel, accountants, Claims Administrators, benefits specialists, consultants, actuaries and other person or persons as it shall deem advisable. The Employer shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

Section 10.04 Delegation of Powers: In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable it properly to carry out such duties.

ARTICLE XI

DISCLAIMER OF LIABILITY

Section 11.01 Disclaimer of Liability: Except as otherwise provided by law, neither the City Council for the City of Irving ("City Council"), the City Manager, the Employer, the Plan Administrator, the trustee (if any) nor any other agent or Retiree of the City of Irving designated to carry out fiduciary responsibilities pursuant to this Plan shall be liable for any act or failure to act, which is made in good faith pursuant to the Plan.

ARTICLE XII

GUARANTEES AND LIABILITIES

Section 12.01 Non-Guarantee of Employment: Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any Participant, or as a right of any Participant to be continued in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of the Participants, with or without cause.

Section 12.02 Non-Alienation of Benefits: No benefit under this Plan shall be subject to anticipation, alienation, sale, transfer, pledge, charge, attachment, assignment, encumbrance, garnishment, execution, or levy of any kind or any other process of law, voluntary or involuntary, including any such benefit intended for support of a spouse or former spouse or other relations of the Participant prior to payment actually being received by the Participant entitled to the benefit under the terms of this Plan, and any attempt to so dispose of any rights to benefits payable hereunder shall be void. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant entitled to benefits hereunder. Notwithstanding the foregoing, a Participant may, with consent of the Plan Administrator and by executing any appropriate forms prescribed by the Claims Administrator, assign payment hereunder to a health care provider to whom the Participant is indebted for Covered Charges, in which case payment to such party shall operate as a complete discharge of the Plan with regard to such benefits.

Section 12.03 Fraud: No payments with respect to Benefits under this Plan will be paid if the Participant or the provider of service attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator shall have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made, and its decision shall be final, conclusive and binding upon all persons. The Plan shall have the right to fully recover any amounts, with interest, improperly paid by the Plan by reason of fraud, attempted fraud or misrepresentation of fact by a Participant or service provider and to pursue all other legal or equitable remedies.

ARTICLE XIII

AMENDMENTS, TERMINATIONS AND MERGERS

Section 13.01 Right to Amend, Merge or Consolidate: The Employer shall have the right to at any time merge or consolidate the Plan, and to make any amendment or amendments to the Plan from time –to time, including those which are retroactive in effect through adoption of a City Council resolution. Such amendments may be applicable to any Participant. Notwithstanding the foregoing, with the approval of the City Manager and the City Attorney and the concurrence of an actuary, the Plan Administrator may amend the Plan to provide different or more generous contributions or benefits for a specific Retiree in connection with the recruitment and/or retention of such Retiree.

Section 13.02 Right to Terminate: The Employer shall have the right at any time to terminate the Plan in whole or in part through adoption of a City Council resolution.

ARTICLE XIV

MISCELLANEOUS LAW PROVISIONS

Section 14.01 Medical Child Support Orders: Notwithstanding any provision of this Plan to the contrary and only to the extent the Plan Administrator determines that any such order is required to be honored by this Plan, this Plan will comply with a child support order as required by state or Federal law, including a medical child support order described in section 1908 of the Social Security Act (as added by section 13822 of OBRA '93).

Section 14.02 Rights of States with Respect to Group Health Plans Where Participants or Beneficiaries Thereunder Are Eligible for Medicaid Benefits:

(i) Compliance by Plans with Assignment of Rights: To the extent required by applicable law, the Plan shall comply with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of OBRA '93).

(ii) Enrollment and Provisions of Benefits Without Regard to Medicaid Eligibility: In determining or making any payments for benefits of a Participant, the fact that the Participant is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account.

(iii) Acquisition by States of Rights of Third Parties: If payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act, in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under this Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services; provided, however, that in no event shall such a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Participant under the Plan, specifically including any state law which provides that a state plan can make a claim for benefits or recover benefits beyond the period permitted under the Plan.

Section 14.03 Mental Health Parity: Notwithstanding any other provision of the Plan (except Section 14.09 below), to the extent required by law, in no event shall the Plan impose any annual or lifetime maximums under the Plan (or under any coverage option under the Plan to claims incurred for the care and treatment of mental or nervous disorders (other than those caused by or relating to alcohol dependency, chemical dependency or substance abuse, except as required by law).

Section 14.04 Compliance with the Mothers' and Newborns' Health Protection Act: Subject to Section 14.09, in no event shall the Plan restrict benefits for any hospital length of stay in

connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Section 14.05 Opt-Out of Compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Mothers' and Newborns' Health Protection Act (MNHPA): The Employer, in its sole discretion and in accordance with regulations promulgated by the Centers for Medicare and Medicaid Services ("CMS"), may elect to opt out of compliance with any provision of the Plan required by HIPAA, MHPAEA and MNHPA, by providing proper written notice of such opt out to CMS and the Participants.

Section 14.06 Women's Health and Cancer Rights Act ("WCRA"): Notwithstanding any other provision of the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998, as amended, to the extent applicable.

Section 14.07 Genetic Information Nondiscrimination Act ("GINA"): Notwithstanding anything in this Plan to the contrary, this Plan will comply with the Genetic Information Nondiscrimination Act of 2008, as amended, to the extent applicable.

Section 14.08 Premium Discounts and Rebates: Notwithstanding the foregoing, nothing in this Section 14.08 will be construed to prevent the Plan from establishing premium discounts or rebates, or modifying otherwise applicable copayments or deductibles in return for adherence to a nondiscriminatory wellness program of health promotion and/or disease prevention as set forth in the Public Health Services Act and its accompanying regulations, as amended ("Public Health Services Act").

Section 14.09 Deemed Amended to Comply with Required Laws and Regulations: Notwithstanding any other provision of the Plan to the contrary, in the event a Federal, State of Texas or local law regulation that affects the operation of the Plan and/or the benefit provided hereunder is enacted or promulgated, the Plan shall be deemed to comply with such law or regulation to the extent and manner determined by the Plan Administrator.

ARTICLE XV

HIPAA PRIVACY AND SECURITY PROVISIONS

Section 15.01 HIPAA Privacy Provisions Effective April 14, 2003, as amended:

(i) Purpose: This Article XV is intended to bring the Plan into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations under 45 C.F.R. Sections 160 through 164 (for purposes of this Article XV, referred to generally as the "HIPAA Privacy Rule") by establishing the extent to which the City of Irving, referred to in this Article XV as the "Plan Sponsor") will receive, use and/or disclose Protected Health Information (as defined in 45 C.F.R. Section 164.501).

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan Administrator has designated the Human Resources Director to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule.

(ii) Required Certification of Compliance by Plan Sponsor: Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that the Plan documents (including this document and any other documents and instruments under which the Plan is established and maintained) have been amended to incorporate the provisions of 45 C.F.R. Section 164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 15.01(iv).

(iii) Permitted Disclosure of Protected Health Information to the Plan Sponsor: Unless otherwise permitted by law, and subject to obtaining written certification pursuant to Section 15.01(ii) above, the Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, may disclose Protected Health Information to the Plan Sponsor solely for the purpose of enabling the Plan Sponsor to perform administrative functions related to the treatment, payment and health care operations of the Plan as defined in 45 C.F.R. Section 164.501; provided, however, that the Plan shall not disclose and may not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. 164520(b)(1)(iii)(C) is included in the appropriate notice. In no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 C.F.R. Section 164.504(f).

(iv) Disclosure of Protected Health Information by Plan Sponsor: The Plan Sponsor agrees that, with respect to any Protected Health Information disclosed to it by the Plan (or a health insurance issuer or HMO with respect to the Plan), it shall:

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

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such 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 employee benefit plan of the Plan Sponsor;

(d) Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses and disclosures provided for of which the Plan Sponsor becomes aware;

(e) Make available Protected Health Information in accordance with 45 C.F.R. Section 164.524;

(f) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. Section 164.526;

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 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 with subpart E of 45 C.F.R. Section 164;

(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 disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure that the adequate separation between the Plan and the Plan Sponsor that is required under 45 C.F.R. Section 164.504(f)(2)(iii) is satisfied.

(v) Disclosures of Summary Health Information and Enrollment and Disenrollment Information to Plan Sponsor: The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information (as defined under 45

C.F.R. 164.504(a)) to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan or (b) modifying, amending, or terminating the Plan. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor.

(vi) Required Separation between Plan and Plan Sponsor: In accordance with the requirements of 45 C.F.R. Section 164.504(f)(2)(iii) and Section 15.01(iv)(j), the following shall apply:

(a) Only employees of the Plan Sponsor (and any successors to their current job titles/positions) set forth in ***Appendix A*** may be given access to Protected Health Information because such access is essential for them to perform their Plan administration duties. ***Appendix A*** may be amended from time to time by the Employer without any formal amendment to this Plan or other formal action of the Plan Administrator or any other person.

(b) The list specified above reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals shall have access to Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions for any use or disclosure of Protected Health Information in violation of, or noncompliance with, the provisions of this Article XV.

(c) The Plan Sponsor shall promptly report any breach, violation, or noncompliance to the Plan and shall cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

(vii) Breach Notification:

(a) Defined Terms.

(1) "Breach" means the acquisition, access, use, or disclosure of an individual's Protected Health Information in a manner not permitted under the HIPAA Privacy Rule. A Breach will be presumed unless this Plan determines there is a low probability that the Protected Health Information has been compromised. A Breach does not include: (A) an unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of

authority and does not result in a further impermissible use or disclosure; (B) an inadvertent disclosure by a person who is authorized to access Protected Health Information to another person authorized to access Protected Health Information at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule; or (C) a disclosure of Protected Health Information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(viii) Notification: Following the discovery of a Breach of unsecured Protected Health Information, this Plan will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and will notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured Protected Health Information involving more than 500 residents of a State or jurisdiction, this Plan will notify the media in accordance with 45 CFR §164.406. "Unsecured Protected Health Information" means Protected Health Information that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Section 15.02 HIPAA Security Requirements

(i) Implementation of Security Safeguards. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information, as defined in the HIPAA Security Rule, that it creates, receives, maintains, or transmits on behalf of the Plan, consistent with the requirements of the HIPAA Security Rule.

(ii) Support of Adequate Separation Requirement by Security Measures. The Plan Sponsor shall ensure that the adequate separation requirement set forth in 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the HIPAA Security Rule.

(iii) Agents and Subcontractors. The Plan Sponsor shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

(iv) Reporting Obligation. The Plan Sponsor shall report to the Plan any Security Incident, as defined in the HIPAA Security Rule, of which it becomes aware.

SIGNATURE

IN WITNESS WHEREOF, the City of Irving has caused this document to be duly executed in its name and on behalf of its City Council thereunto duly authorized to be effective as of October 1, 2023.

CITY OF IRVING

the "Employer"

By: _____

Title: _____

ATTEST:

_____
City Secretary

APPENDIX A
HIPAA PRIVACY - ACCESS

This ***Appendix A*** will be subject to modification without any formal amendment to this Plan or other formal action of the Plan Administrator or any other person. To the extent that this ***Appendix A*** is modified, such modified ***Appendix A*** will replace and supersede the prior version of ***Appendix A*** upon the effective date of the modified appendix.

The following employees of the Plan Sponsor (and any successors to their current job titles/positions) may be given access to PHI because such access is essential for them to perform their Plan administration duties:

- Human Resources Director
- Workforce Services Manager
- Benefits Administrator
- Risk and Benefits Advisor
- Benefits Assistant
- Workforce Services Assistant
- Software Services Manager
- Senior Software Services Analyst

This ***Appendix A*** is effective on and after: **October 1, 2023**.