# WRIGHT STATE UNIVERSITY
# 2020 RETIREE HEALTH REIMBURSEMENT PLAN

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TABLE OF CONTENTS

ARTICLE 1
INTRODUCTION

Section 1.01 PLAN

This Wright State University 2020 Retiree Health Reimbursement Plan (the "Plan") is intended to qualify as a retiree health reimbursement arrangement that provides benefits that are excludable from gross income under Code Section 105(b) and shall be administered in accordance with IRS Notice 2002-45 and IRS Revenue Ruling 2002-41. This Plan shall be established as of July 1, 2020.

Section 1.02 APPLICATION OF PLAN

Except as otherwise specifically provided herein, the provisions of this Plan shall apply to those individuals who are Eligible Retirees of the Plan Sponsor on or after the Effective Date. Only those retirees who enroll in the Wright State University 2020 Faculty Voluntary Retirement Incentive Plan (FVRIP) will be eligible to participate in this Plan; any current active Employees or retired Employees who did not enroll in the 2020 Faculty Voluntary Retirement Incentive Plan (FVRIP) will not be eligible for this Plan or any benefit that the Plan provides.

ARTICLE 2
DEFINITIONS

"Beneficiary" shall mean, in the event of a death, the spouse and/or dependents of the Participant at the time of the Participant's retirement. An eligible spouse and/or dependents are determined in accordance with Article 3 and Section 6.03.

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

"Covered Person" shall mean any "Eligible Retiree" and his or her eligible spouse and dependents (including his Beneficiary(ies)) in accordance with Article 3.

"Effective Date of Coverage" shall mean the later of July 1, 2020 or the first day of the month following retirement.

"Eligible Retiree" means any retiree who enrolled in the Wright State University's 2020 Faculty Voluntary Retirement Incentive Plan (FVRIP) in accordance with Articles 3 and 4 and the terms of the -FVRIP.

"Eligible Expenses" shall generally mean expenses incurred by a Participant or other Covered Person for medical care, as defined in Code Section 213(d) (including, for example, amounts for certain hospital, doctor, and dental bills), as further modified by Section 4.01(c) and (d) of the Plan.

"Employee" means any individual who is employed by the Employer. The term "Employee" shall not include: (i) a self-employed individual (including a partner) as defined in Code Section 401(c), or (ii) any person who owns (or is considered as owning within the meaning of Code Section 318) more than 2 percent of the outstanding stock of an S corporation.

"Employer" means the Plan Sponsor or any other employer required to be aggregated with the Plan Sponsor under Code Sections 414(b), (c), (m) or (o); provided, however, that "Employer" shall not include any entity or unincorporated trade or business prior to the date on which such entity, trade or business satisfies the affiliation or control tests described above.

"Health Reimbursement Account" means the balance of a hypothetical account established pursuant to Section 4.01 for each Participant as of the applicable date and such other account(s) or subaccount(s) as the Plan Administrator, in its discretion, deems appropriate.

"Participant" shall mean an Eligible Retiree who has satisfied all requirements to enroll in the Plan pursuant to Article 3.

"Period of Coverage" shall mean the three years that a Covered Person is able to incur expenses under the Plan and any modifications made to this term found in Section 4.03, except where otherwise noted.

"Plan" means this Wright State University 2020 Retiree Health Reimbursement Plan.

"Plan Administrator" means the person(s) designated pursuant to Section 7.01.

"Plan Sponsor" means Wright State University.

"Plan Year" whenever this term appears it shall be applied to the first three years of the Period of Coverage under this Plan. Plan Year shall also mean a 12 consecutive month period.

"Run-out Period" will be three months and it will begin immediately after the last day of the Period of Coverage.

ARTICLE 3
PARTICIPATION

Section 3.01 PARTICIPATION

Each Eligible Retiree who satisfies all requirements to enroll in the Plan shall be a Participant in the Plan on the Effective Date of Coverage.

No previously retired Employee or currently active Employee shall be eligible for this Plan or any benefits that the Plan provides if they did not enroll in the Plan Sponsor's 2020 Faculty Voluntary Retirement Incentive Plan (FVRIP).

An Eligible Retiree's spouse and dependents will be considered Covered Persons under this Plan. A spouse must meet the following criteria: (i) is currently the lawfully married spouse of an Eligible Retiree and (ii) was the lawfully married spouse of an Eligible Retiree at the time of the Eligible Retiree's Effective Date of Coverage. Subject to the COBRA provisions set forth in Section 3.04, any spouse who at any point divorces or legally separates from the Eligible Retiree shall no longer be considered eligible under the Plan, regardless of whether the divorce decree or court order requires the Eligible Retiree to provide coverage to his or her former spouse. A dependent must meet the following criteria: (i) the dependent is under the age of twenty-seven and is (a) the biological child of an Eligible Retiree, or (b) a child legally adopted by an Eligible Retiree or placed with an Eligible Retiree for adoption, or (c) an Eligible Retiree's stepchild, or (d) a person over which an Eligible Retiree has legal guardianship. To qualify as a dependent, the individual must meet the foregoing criteria at the time of the Eligible Retiree's Effective Date of Coverage. Subject to the COBRA provisions set forth in Section 3.04, any child who attains the age of twenty-seven will no longer considered to be eligible for any benefits from this Plan on the last day of the month in which they attain the age of twenty-seven.

Persons who will not be considered Covered Persons under the Plan will include: (i) a grandchild, unless the grandchild meets the criteria in the previous paragraph, (ii) a child for whom the Eligible Retiree's parental rights have ended in accordance with state law, and (iii) parents and grandparents of the Eligible Retiree.

Section 3.02 DEATH OF ELIGIBLE RETIREE

In the event of the death of the Eligible Retiree, a designated Beneficiary will be allowed to continue participation until the end of the Period of Coverage (and submit claims during the three-month Run-out Period pursuant to Section 6.01(a)). All outstanding Health Reimbursement Account credits contemplated under Section 4.01(a) will continue to be made through the earlier of (i) end of the Period of Coverage or (ii) the date of the death of the last designated Beneficiary. Such remaining Health Reimbursement Account credits will be available for reimbursement of Eligible Expenses of the Beneficiary incurred during the Period of Coverage, and submitted no later than the end of the Run-out Period.

Section 3.03 PROCEDURES FOR ADMISSION

The Plan Administrator shall prescribe such forms and may require such data from Eligible Employees as are reasonably required to enroll such Eligible Employee in the Plan or to effectuate any Participant elections i.e., such as Beneficiary, spouse and/or dependent information. The Plan Administrator may impose other limitations and/or conditions with respect to participation in the Plan on an Eligible Retiree who commences or recommences participation in the Plan pursuant to Section 3.03.

Section 3.04 COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), the Participant and his or her eligible spouse and dependents (Qualified Beneficiaries), whose coverage terminates under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the Plan on the day before the qualifying event for the periods prescribed by COBRA (subject to all

conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. At the beginning of each month in the Period of Coverage, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (*i.e.*, the maximum annual reimbursement amount, divided by the number of months in that Period of Coverage) that is made available to similarly situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Period of Coverage shall be carried over to the next Period of Coverage (provided that the applicable premium is paid). A premium for COBRA continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA.

ARTICLE 4
ACCOUNTS

Section 4.01 HEALTH REIMBURSEMENT ACCOUNTS

(a) Credits. Each Eligible Retiree's Health Reimbursement Account shall be credited $5,000 each year, for the first three years of the Period of Coverage, according to the following schedule:

(1) The first annual contribution shall be made by the later of (i) July 31, 2020 or (ii) the end of the first month immediately following the Eligible Retiree's retirement from service.

(2) The second annual contribution shall be made by the later of (i) July 31, 2021 or (ii) the end of the thirteenth month immediately following the Eligible Retiree's retirement from service.

(3) The third annual contribution shall be made by the later of (i) July 31, 2022 or (ii) the end of the twenty-fifth month immediately following the Eligible Retiree's retirement from service.

(b) Debits. Each Participant's Health Reimbursement Account shall be debited for Eligible Expenses described in Subsection (c). Each Eligible Retiree's Health Reimbursement Account will be debited an annual equivalency of $3.50 per month, the first, thirteenth, twenty-fifth, and thirty-seventh month during the Period of Coverage.

(c) Eligible Expenses. A Participant may be reimbursed from his or her Health Reimbursement Account for Eligible Expenses incurred by Covered Persons provided such expenses are (i) incurred during the first three years of participation in the Plan, (ii) incurred while the Participant participates in the Plan, (iii) not attributable to a deduction allowed under Code Section 213 for any prior taxable year, and (iv) not covered, paid or reimbursed from any other source. A participant may not be reimbursed for unprescribed medicines or drugs (other than insulin), without regard to whether such medicine or drug could be obtained without a prescription.

(d) Eligible Premiums. Subject to the limitations set forth in Section 4.01(c), and only to the extent permitted under IRS Notice 2002-45, a Participant may be reimbursed from his or her Health Reimbursement Account for "Eligible Premiums" (as defined in Code Section 213(d)(1)(D)) incurred by Covered Persons, provided such premiums were paid with after-tax dollars to their insurance provider. For example, premiums paid with pre-tax dollars are not eligible for reimbursement.

Section 4.02 FORFEITURES/TRANSFERS

(a) Forfeitures. Any balance remaining after the Run-out Period shall be forfeited back to the Employer and no funds will be available for reimbursement after this period.

(b) Carryovers. Any unused amounts remaining at the end of each Plan Year shall carryover in full to be used for any future Plan Years during the Period of Coverage.

Section 4.03 PERIOD OF COVERAGE AND RUN-OUT PERIOD

(a) Period of Coverage. The Period of Coverage will be three years from the Eligible Retiree's Effective Date of Coverage in the Plan. During this period the Eligible Retiree and any other Covered Person may incur expenses to be reimbursed from the Plan. A Covered Person's eligibility may be suspended or terminated pursuant Sections 3.01 through 3.03.

(b) Run-Out Period. The Run-out Period shall be the period that the Participant or any Beneficiary has, pursuant to Sections 3.02 and 6.01(a), to submit any claims that were made during the Period of Coverage. The Run-out Period will be three months and it will begin immediately after the last day of the Period of Coverage. After the Run-out Period has ended, any remaining balance will be forfeited pursuant Section 4.02.

## ARTICLE 5
## NONDISCRIMINATION

The Plan may not discriminate in favor of highly compensated employees (within the meaning of Code Section 105(h)(5)) as to benefits provided or eligibility to participate with respect to the Health Reimbursement Account.

If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code (including the exemption from such requirements for certain self-insured, retiree-only arrangements under Treas. Reg. Section 1.105-11(c)(3)(iii)), the Plan Administrator may modify any eligibility requirement or benefit amount under the Plan in order to assure compliance with such requirements or limitations. Any act taken by the Plan Administrator under this Article 5 shall be carried out in a uniform and non-discriminatory manner.

ARTICLE 6
REIMBURSEMENTS

Section 6.01 PROCEDURES FOR REIMBURSEMENT

(a) Timing of Claims. Reimbursements and/or payments shall only be made for Eligible Expenses of a Participant or other Covered Person incurred during Period of Coverage. Except as otherwise expressly provided herein, no reimbursement and/or payment shall be made for any expenses relating to services rendered before participation or after the Period of Coverage has ended. All claims for reimbursement can be submitted during the Period of Coverage or during the three-month Run-out Period.

(b) Documentation. A Participant or any other person entitled to benefits from the Plan (a "Claimant") may apply for such benefits by completing and filing a claim with the Plan Administrator. Any such claim shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate the claim.

(c) Payment. To the extent that the Plan Administrator approves the claim, the Plan Sponsor shall: (i) reimburse the Claimant, or (ii) at the option of the Plan Administrator, pay the service provider directly for any amounts payable from the Health Reimbursement Account. The Plan Administrator shall establish a schedule, not less frequently than weekly, for the payment of claims. The Plan Administrator may provide that payments/reimbursements of less than certain amount may be carried forward and aggregated with future claims until the reimbursable amount is greater than such minimum, provided, however, that the entire amount of payments/reimbursements outstanding at the end of the Period of Coverage shall be reimbursed without regard to the minimum payment amount (provided sufficient amounts remain in the Participant's notional Health Reimbursement Account to pay such outstanding payments/reimbursements).

(d) Coordination with Cafeteria Plan. A Participant shall not be entitled to payment/reimbursement under a health care reimbursement account in a cafeteria plan sponsored by the Plan Sponsor to the extent the expense is reimbursable under this Plan.

(e) Form of Claim/Notice. All claims and notices shall be made in written form unless the Plan Administrator provides procedures for such claims and notices to be made in electronic and/or telephonic format to the extent that such alternative format is permitted under applicable law.

(f) Refunds/Indemnification. If the Plan Administrator determines that any Claimant has directly or indirectly received excess payments/reimbursements or has received payments/reimbursements that are taxable to the Claimant, the Plan Administrator shall notify the Claimant and the Claimant shall repay such excess amount (or at the option of the Plan Administrator, the Claimant shall repay the amount that should have been withheld or paid as payroll or withholding taxes) as soon as possible, but in no event later than 30 days after the date of notification. A Claimant shall indemnify and reimburse the Plan Sponsor for any liability the Plan Sponsor may incur for making such payments, including but not limited to failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If the Claimant fails to timely repay an excess amount and/or make sufficient indemnification, the Plan Administrator may offset other benefits payable hereunder.

(g) Plan Administrator Procedures. The Plan Administrator may establish procedures regarding the documentation to be submitted in a claim for reimbursement and/or payment and may also establish any other procedures regarding claims for reimbursement and/or payment. Such procedures may include, without limitation, requirements to submit claims periodically throughout the Period of Coverage.

Section 6.02 CLAIMS PROCEDURE

(a) A request for benefits is a "claim" subject to this Section only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing. Any claim that does not relate to a specific benefit under the Plan (for example, a general

eligibility claim) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information. Participants may designate an authorized representative if written notice of such designation is provided.

(b) Because the Plan is a governmental, retiree-only arrangement, the Plan is not subject to the Employee Retirement Income Security Act of 1974 (including claim and appeal regulations thereunder) or the internal/external appeal requirements under the Patient Protection and Affordable Care Act. Consequently, claims procedures shall be established by the policies and procedures of the Plan Administrator and/or Plan Sponsor and any other applicable law.

Section 6.03 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Plan Sponsor from further liability on account thereof.

Section 6.04 MISSING PAYEE

If the Plan 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 Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 7
PLAN ADMINISTRATION

Section 7.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Sponsor shall be the Plan Administrator, unless the Plan Sponsor designates a Committee to act as the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be Employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 6;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of Employees and of the status of rights of Participants;

(ix) to adjust Accounts in order to correct errors or omissions;

(x) to determine the validity of any judicial order;

(xi) to retain records on elections and waivers by Participants;

(xii) to supply such information to any person as may be required; and

(xiii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan

Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Plan Sponsor, with the exception of the $3.50 monthly administrative fee to be paid by the Participant in accordance to Article 4.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 7.02 RESPONSIBILITY OF PLAN SPONSOR

To the extent permitted by law, the Plan Sponsor shall be responsible to any person serving as the Plan Administrator (and its delegate) for all liabilities incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of such person’s fiduciary duties under this Plan.

Section 7.03 MEDICAL CHILD SUPPORT NOTICES

In the event that an Eligible Retiree is required under a National Medical Support Notice (NMSN) to cover his or her child under the Plan, the child will be eligible under the Plan if Wright State University determines that the order is a qualified NMSN. Eligible Employees must notify Wright State as soon as possible if an order is issued for a child.

Section 7.04 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) In General. When a Participant or other Covered Person receives Plan benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

(b) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or other Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to subrogation applies regardless of the manner in which the recovery is structured or worded, and even if the Participant or other Covered Person has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or other Covered Person may be entitled. The Plan will

not pay attorney fees or costs associated with the claim or lawsuit without express written authorization from the Plan Sponsor.

If the Plan should become aware that a Participant or other Covered Person has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and other Covered Persons until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or other Covered Persons.

(c) Participant Duties and Actions. By participating in the Plan, each Participant and other Covered Person consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and other Covered Person agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or other Covered Person has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or other Covered Person to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Participant or other Covered Person until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or other Covered Person, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and other Covered Person consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

## ARTICLE 8
## AMENDMENT AND TERMINATION

Section 8.01 AMENDMENT

The provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor.

Section 8.02 TERMINATION

The Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

ARTICLE 9
MISCELLANEOUS

Section 9.01 NONALIENATION OF BENEFITS

No Participant or other Covered Person shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which he may expect to receive, contingently or otherwise, under the Plan.

Section 9.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Plan Sponsor and the Participant, or as a right of any Employee to continue in the employment of the Plan Sponsor, or as a limitation of the right of the Plan Sponsor to discharge any of its Employees, with or without cause.

Section 9.03 NO FUNDING REQUIRED

Except as otherwise required by law and subject to the COBRA provisions in Section 3.5:

(a) Any amount contributed by the Plan Sponsor to provide benefits hereunder shall remain part of the general assets of the Plan Sponsor and all payments of benefits under the Plan shall be made solely out of the general assets of the Plan Sponsor.

(b) The Plan Sponsor shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Plan Sponsor may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any Health Reimbursement Account other than as expressly authorized in the Plan.

Section 9.04 GOVERNING LAW

(a) The Plan shall be construed in accordance with and governed by the laws of the state of Ohio to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 9.05 TAX EFFECT

The Plan Sponsor does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 9.06 SEVERABILITY OF PROVISIONS

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

Section 9.07 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 9.08 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

ARTICLE 10
HIPAA PRIVACY AND SECURITY COMPLIANCE

This Article 10 shall only apply in the event that the Plan constitutes a group health plan as defined in Section 2791(a)(2) of the Public Health Service Act or if the Plan Administrator determines that the Plan is subject to the HIPAA privacy and security rules. The Plan will comply with HIPAA as set forth below.

Section 10.01 DEFINITIONS

For purposes of this Article 10, the following terms have the following meanings:

(a) "Business Associate" means any outside vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

(b) "Group Health Benefits" means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

(c) "Individual" means the Participant or other Covered Person enrolled in any of the Group Health Benefits under the Plan.

(d) "Notice of Privacy Practices" means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

(e) "Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

(f) "Protected Health Information ("PHI")" means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) "Summary Health Information "means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five-digit zip code;

(3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and

all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 10.02 HIPAA PRIVACY COMPLIANCE.

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan Participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to cover Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those Employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of Employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each Employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this Section,

the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 10.03 HIPAA SECUIRITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

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

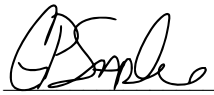
(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

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

(d) Report to the Plan any security incident of which it becomes aware.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Wright State University 2020 Retiree Health Reimbursement Plan, Wright State University has caused this Plan to be executed in its name and on its behalf, on this 5th day of March, 2020.

WRIGHT STATE UNIVERSITY

By: 

Its: Chief Operating Officer

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