



**PUBLIC EMPLOYEES
RETIREMENT SYSTEM OF OHIO
RETIREE MEDICAL ACCOUNT**

2022

Includes amendments adopted through January 1, 2022

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PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
RETIREE MEDICAL ACCOUNT

Includes amendments adopted through January 1, 2022

**PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
RETIREE MEDICAL ACCOUNT**

WHEREAS, the Public Employees Retirement System of Ohio (“System”) desires to promote the health and efficiency of its Members, and

WHEREAS, the System is authorized by section 145.83 of the Ohio Revised Code to establish a program under which Participants in the Public Employees Retirement System of Ohio Defined Contribution Plan (“Defined Contribution Plan”) will have a portion of the amount under sections 145.86 and 145.88 of the Ohio Revised Code contributed to the trust established by the OPERS TR Agreement for Funding Employee Benefit Plans (the “Trust”) under Section 115 of the Internal Revenue Code (“Code”), for the purpose of providing funds to the Participant and their Dependents for the payment of health, medical, hospital, surgical, dental, or vision care expenses, including insurance premiums, deductible amounts, or copayments;

WHEREAS, subject to appropriate enabling legislation and approval from the Internal Revenue Service, eligible Participants in the Defined Contribution Plan, the Public Employees Retirement System of Ohio Defined Benefit Plan, or the Public Employees Retirement System of Ohio Combined Defined Benefit/Defined Contribution Plan, may make additional voluntary employee contributions for the purpose of funding health, medical, hospital, surgical, dental, or vision care expenses, including insurance premiums, deductible amounts, or copayments;

NOW THEREFORE, effective January 1, 2003, the System hereby establishes the Public Employees Retirement System of Ohio Retiree Medical Account, formerly named the Public Employees Retirement System of Ohio VEBA Health Plan through June 30, 2016, the Plan for the Trust established pursuant to Code Section 115.

(Title and Preamble amended: 7/1/16)

ARTICLE I DEFINITIONS

1.01 “Accounts” mean the Employee Contribution Account and/or Employer Contribution Account maintained by the Administrator for a Participant in the Plan.

1.02 “Administrator” means the Public Employees Retirement Board or Public Employees Retirement System, as appropriate.

1.03 “Board” means the Public Employees Retirement Board, as established by section 145.04 of the Ohio Revised Code

1.04 “Code” means the Internal Revenue Code of 1986, as amended, applicable to governmental plans and, where appropriate, the Internal Revenue Code of 1954.

1.05 “Combined Plan” means the Public Employees Retirement System of Ohio Combined Defined Benefit/Defined Contribution Plan established pursuant to sections 145.80 to 145.98 of the Ohio Revised Code.

1.06 “**Defined Contribution Plan**” means the Public Employees Retirement System of Ohio Defined Contribution Plan established pursuant to sections 145.80 to 145.98 of the Ohio Revised Code.

1.07 “**Defined Benefit Plan**” means the Public Employees Retirement System of Ohio Defined Benefit Plan established and described in sections 145.201 through 145.70 of the Ohio Revised Code.

1.08 “**Dependent**” means a dependent for purposes of sections 105 and 106 of the Internal Revenue Code of 1986, 26 U.S.C.A. 105, 106, and is described as one of the following:

- (a) The spouse who is legally married to a Participant as determined under the laws of any state as of the first day of any month.
- (b) The biological or legally adopted child of a Participant who is under the age of twenty-six.
- (c) The grandchild of a Participant for whom the Participant has been ordered pursuant to section 3109.19 of the Revised Code, or equivalent order from another state, to provide for the health care coverage.

(Section 1.08 amended: 9/28/06, 1/1/22)

1.09 “**Employee**” means a public employee, as defined in section 145.01 of the Ohio Revised Code.

1.10 “**Employee Contribution Account**” means the account maintained by the Administrator for a Participant in the Plan to which shall be credited contributions made pursuant to Section 3.02.

1.11 “**Employer or “Public Employer”**” has the same meaning as set forth in section 145.01 of the Ohio Revised Code.

1.12 “**Employer Contribution Account**” means the account maintained by the Administrator for a Participant in the Plan to which shall be credited contributions made pursuant to Section 3.01.

1.13 “**Medical Benefits**” means medical benefits as defined in Article V of this Plan.

1.14 “**Member**” has the same meaning as set forth in section 145.01 of the Ohio Revised Code.

1.15 “**Participant**” means a Member who is participating or has participated in this Plan and who still has an Account balance in this Plan.

1.16 “**Plan**” means the Public Employees Retirement System of Ohio Retiree Medical Account established pursuant to section 145.83 of the Ohio Revised Code and the appropriate enabling legislation, and as described in this Plan document.

(Section 1.16 amended: 7/1/16)

1.17 “**Plan Year**” means a calendar year.

1.18 “**Public Service Terminates**” has the same meaning as set forth in section 145.01 of the Ohio Revised Code.

1.19 “**Service Manager**” means the individual or entity appointed by the Administrator to perform third party administrative functions and services for the Plan.

1.20 “**State**” means the State of Ohio.

1.21 “**System**” means the Public Employees Retirement System of Ohio.

1.22 “**Trust**” means the trust established by the OPERS TR Agreement for Funding Employee Benefit Plans (the “Trust”) established under Section 115 of the Code.

(Section 1.22 amended: 7/1/16)

1.23 “**Trustees**” means the Ohio Public Employees Retirement Board.

1.24 “**Year of Participation**” has the same meaning as set forth in the Defined Contribution Plan.

Words used herein in the masculine or feminine gender shall be construed to include the feminine or masculine gender where appropriate and words used herein in the singular or plural shall be construed as being in the plural or singular where appropriate.

ARTICLE II PARTICIPATION

2.01 **Mandatory Participation.** Subject to the limitations of Section 2.03, a Member who is a Participant in the Defined Contribution Plan becomes a Participant under this Plan at the time an Employer begins to make contributions to the Defined Contribution Plan on behalf of the Member pursuant to Article III of the Defined Contribution Plan.

2.02 **Voluntary Participation by Members.** Subject to the limitations of Section 2.03, a Member who is a Participant in the Combined Plan, the Defined Benefit Plan, or Defined Contribution Plan may become a Participant under this Plan at the time the Member begins to make contributions to the Plan pursuant to Article III. In the event that the eligibility of any Member to participate in the Trust is disputed, the decision of the Administrator or Service Manager on such eligibility shall be final and conclusive.

2.03 **Limitations.** This Plan does not permit any condition for eligibility or benefits which would discriminate in favor of any class of Participants to the extent such discrimination

is prohibited by applicable law. The compensation of any Participant taken into account under this Plan shall not exceed the annual limitation under Code Section 505(b)(7), as adjusted under Code Section 401(a)(17)(B).

2.04 Eligibility for Payment of Medical Benefits.

(a) A Participant and the Participant's Dependents become eligible for payment of Medical Benefits from the Plan, pursuant to Articles IV and VI, as follows:

(1) For a Participant described in Section 2.01, after the Participant's Public Service terminates and the System processes a distribution under Article VIII of the Defined Contribution Plan or on the effective date of a payment option under Article IX of the Defined Contribution Plan;

(2) For a Participant described in Section 2.02, after the Participant's Public Service terminates and the Participant receives a distribution under Article VIII or IX of the Combined Plan, under Article VIII or IX of the Defined Contribution Plan, or under sections 145.32, 145.33, 145.331, 145.34, 145.36, 145.361, 145.37 and 145.40 of the Ohio Revised Code as a Member participating in the Defined Benefit Plan, or, under section 145.45 of the Ohio Revised Code, as a Member's survivor and Dependent, including Members or survivors who transferred to the Defined Benefit Plan under Article X of the Combined Plan. For a Participant receiving a benefit under section 145.36 or 145.361 of the Ohio Revised Code as a Member participating in the Defined Benefit Plan, including a Member who transferred to the Defined Benefit Plan under Article X of the Combined Plan, if such Participant's disability terminates and the Participant returns to covered employment with a Public Employer, the Participant shall no longer be eligible for payment of Medical Benefits from the Plan until again satisfying the requirements of this Section.

(b) A Participant is not eligible for payment of Medical Benefits on the date the Participant returns to employment with or provides any service to a Public Employer. The suspension of Medical Benefits shall end on the day following the Participant's last day of employment with or service to a Public Employer. If a Participant dies during a period of suspension, the Account shall be governed by Section 4.02(c) of the Plan.

(c) A Participant who made an election under Article VI of the Defined Contribution Plan is not eligible for payment of Medical Benefits until the Participant elects to receive a distribution under the new plan.

(d) After the death of a Participant, any remaining Account balance may be used by the Participant's Dependents for the payment of eligible Medical Benefits and subject to Section 4.02(c) of the Plan.

(Section 2.04 amended: 3/23/15)

2.05 Duration of Participation for Participants and Dependents. Once a Member becomes a Participant in the Plan, the right of a Participant and the Participant's Dependents to

participate in the Plan continues as long as funds remain in the Participant's Accounts. If the Participant dies prior to exhausting the funds in his or her Accounts, the Participant's Dependents may use the funds in the Accounts for eligible Medical Benefits as permitted under this Plan. Any funds remaining after the death of all Dependents of the Participant shall be forfeited under Section 4.02 of the Plan.

2.06 Transfers. The Trustees, upon such terms and conditions as they deem appropriate, may accept into the Trust Fund a transfer of assets from another plan and trust which meets the requirements of a trust under Code Section 115.
(Section 2.06 amended: 7/1/16)

ARTICLE III FUNDING OF BENEFITS

3.01 Mandatory Contributions. For each Participant described in Section 2.01 of the Plan, the Administrator shall withhold a portion of the employer contribution under section 145.86 of the Ohio Revised Code, as described in section 145.88 of the Ohio Revised Code, and shall credit the contributions withheld to the Participant's Employer Contribution Account for the purpose of providing for payment of the Medical Benefits described under Article VI. The portion of a Participant's Employer Contribution Account available for the payment of Medical Benefits shall be determined in accordance with Article IV of the Plan.

3.02 Voluntary Contributions.

(a) **After-Tax Voluntary Contributions.** Subject to authority granted under Chapter 145. of the Ohio Revised Code, a Member who becomes a Participant under Section 2.02 of the Plan may make contributions, on an after-tax basis, which are separate from the contributions by the Member under section 145.47 or 145.85 of the Ohio Revised Code, and the Administrator shall credit the contributions made to the Participant's Employee Contribution Account for the purpose of providing for the payment of the Medical Benefits described under Article VI. The Member may make after-tax contributions through payroll deduction or direct payment, as provided in rules or procedures adopted by the Administrator.

(b) **Pre-Tax Voluntary Contributions.** Subject to authority granted under Chapter 145. of the Revised Code and receipt of a favorable ruling from the Internal Revenue Service, a Member who becomes a Participant under Section 2.02 of the Plan may make contributions, on a pre-tax basis, which are separate from the contributions by the Member under section 145.47 or 145.85 of the Ohio Revised Code, and the Administrator shall credit the contributions made to the Participant's Employee Contribution Account for the purpose of providing for the payment of the Medical Benefits described under Article VI.

(1) **One-Time Elective Contributions.** A Member who elects to contribute under this paragraph shall make a one-time irrevocable election, on a form provided by the Administrator, to reduce the Member's compensation by a specified percentage or dollar amount per payroll period, subject to the following:

(i) The Member must make the election within twenty-four (24) months of becoming eligible to participate in the Plan. The election, once made, will remain in effect until the Member's separation from service with the Employer. Only one irrevocable election may be executed throughout a Member's employment with an Employer (even if a Member separates from service from an Employer and returns to work for the same Employer). Thus, if a Member leaves employment with an Employer and subsequently returns to employment with that same Employer, an election previously made under this paragraph (b) while employed by that Employer will again become effective until another separation from service. An election under this paragraph (b) will remain in effect if a Participant changes participation to a different retirement plan under the System without an accompanying separation of service.

(ii) The total amount of a Participant's one-time elective reduction amount, when added to any other contributions made to this Plan on behalf of that Participant, shall not exceed ten percent (10%) of the Participant's annual compensation. The election shall only apply to amounts earned after the election is made.

(2) **Employee Leave Conversion Contributions.** If an Employer provides for mandatory severance pay and/or leave (including, but not limited to, annual leave, personal leave, sick leave) conversions that cover only a portion of the Member's leave balance or severance pay, the Member may make an annual (or end of service) irrevocable election to convert an additional amount of leave or severance pay. Employee leave conversion contributions may only be made in the form approved by the Trustees.

3.03 Employer Obligations. Beyond an Employer's duty to remit contributions and reports on a timely basis in accordance with Chapter 145. of the Ohio Revised Code and any applicable rules adopted thereunder, an Employer has no obligation to each Participant under this Plan.

3.04 Receipt of Deposits. Deposits for any Plan Year will be credited as received by the Administrator.

ARTICLE IV AMOUNTS AVAILABLE FOR BENEFITS

4.01 Amounts Available for Benefits.

(a) Mandatory Participants under Section 2.01 of the Plan.

(1) A Participant whose participation in the Plan commences on or before June 30, 2015, pursuant to Section 2.01 or 2.02 of the Defined Contribution Plan, or whose participation in the Plan commences on or before July 1, 2015, pursuant to Section 2.03 of the Combined Plan or Rule 145-1-88 of the Administrative Code, and whose

Public Service Terminates with one (1) or more Years of Participation, the Participant or the Participant's Dependents may be entitled to use the following portion of the Employer Contribution Account for Medical Benefits upon satisfying the provisions of Section 2.04(a)(1) of the Plan:

Years of Participation	Available Portion of Employer Contribution Account
1 year	20%
2 years	40%
3 years	60%
4 years	80%
5 years	100%

The remaining portion of the Employer Contribution Account shall be forfeited in accordance with Section 4.02 of the Plan.

(2) A Participant whose participation in the Plan commences on and after July 1, 2015, pursuant to Section 2.01 of the Defined Contribution Plan, or whose participation in the Plan commences on and after August 1, 2015, pursuant to Section 2.03 of the Combined Plan or Rule 145-1-88 of the Administrative Code, and whose Public Service Terminates with six (6) or more Years of Participation, the Participant or the Participant's Dependents may be entitled to use the following portion of the Employer Contribution Account for Medical Benefits upon satisfying the provisions of Section 2.04(a)(1) of the Plan.

Years of Participation	Available Portion of Employer Contribution Account
6 years	10%
7 years	20%
8 years	60%
9 years	40%
10 years	50%
11 years	60%
12 years	70%
13 years	80%
14 years	90%
15 years	100%

The remaining portion of the Employer Contributions Account shall be forfeited in accordance with Section 4.02 of the Plan.

(3) Regardless of the Participant's Years of Participation, a Participant who changes the Participant's retirement plan under Section 2.03 of the Defined Contribution Plan and elects a transfer under Article VI of the Defined Contribution Plan shall not be entitled to use any portion of the Participant's Employer Contribution Account for Medical Benefits and the Employer Contribution Account shall be forfeited in accordance with Section 4.02 of the Plan.

(4) Regardless of the Participant's Years of Participation, the Participant's Employer Contribution Account shall be forfeited in accordance with Section 4.02(c) of the Plan following the death of the Participant.

(Section 4.01(a) amended: 12/1/08; 3/23/15)

(b) **Voluntary Participants under Section 2.02 of the Plan.** Subject to Section 4.02 of the Plan, 100% of the Participant's Employee Contribution Account shall be available for use to fund Medical Benefits, upon satisfying the provisions of Section 2.04(a)(2) of the Plan.

4.02 Forfeitures.

(a) Mandatory Participants under Section 2.01 of the Plan.

(1) If a Participant described in Section 4.01(a)(1) of the Plan terminates public service with less than one (1) Year of Participation and the Participant receives a distribution under Article VIII or IX of the Defined Contribution Plan, the Participant's Employer Contribution Account shall be forfeited. If a Participant described in Section 4.01(a)(2) of the Plan terminates public service with less than six (6) Years of Participation and the Participant receives a distribution under Article VIII or IX of the Defined Contribution Plan, the Participant's Employer Contribution Account shall be forfeited.

(2) If a Participant described in Section 4.01(a)(1) of the Plan terminates public service with more than one (1) Year of Participation and the Participant receives a distribution under Article VIII or IX of the Defined Contribution Plan, the portion of the Participant's Employer Contribution Account that is not available for Medical Benefits under Article VI of the Plan shall be forfeited. If a Participant described in Section 4.01(a)(2) of the Plan terminates public service with more than six (6) Years of Participation and the Participant receives a distribution under Article VIII or IX of the Defined Contribution Plan, the portion of the Participant's Employer Contribution Account that is not available for Medical Benefits under Article VI of the Plan shall be forfeited.

(3) If a Participant described in Section 2.01 of the Plan changes his or her retirement plan under Section 2.03 of the Defined Contribution Plan and elects a transfer

under Article VI of the Defined Contribution Plan, the Participant's Employer Contribution Account shall be forfeited.

(Section 4.02(a) amended: 3/23/15)

(b) **Voluntary Participants under Section 2.02 of the Plan.** The Participant's Employee Contribution Account shall be forfeited in accordance with Section 4.02(c) of the Plan.

(c) **All Participants.** If a Participant is deceased and there are no remaining Dependents of the Participant eligible for Medical Benefits under the Plan, all funds in the Participant's Employee Contribution Account or Employer Contribution Account shall be forfeited. An authorized representative of a deceased Participant may submit a claim for reimbursement from the remaining balance in the Account for any Medical Benefits incurred by the deceased Participant prior to death. Claims for reimbursement of such Medical Benefits must be submitted to the Administrator within 24 months of the Participant's death. The balance of the deceased Participant's Account shall be forfeited upon the expiration of the 24-month period following the date of death. Accounts that are payable and unclaimed following a Participant's death shall also be forfeited and may be used in accordance with Section 4.02(d) of the Plan if either of the following occur:

(1) The Service Manager has not received any claims for reimbursement from a Dependent within two years of the death of the Participant; or

(2) A Dependent has made a claim for reimbursement within two years of the Participant's death, but fails to make a claim at least once within the twenty-four month period following the date the most recent claims was submitted.

(Section 4.02(c) amended: 3/23/15, 7/1/16)

(d) **Use of Forfeitures.** Forfeitures shall be used for administrative expenses of the Plan or, for Participants described in Section 2.01 of the Plan, may be used as a credit against future Employer contributions to the Plan.

ARTICLE V ACCOUNTS AND REPORTS

5.01 Participant's Accounts. For each Participant described in Section 2.01 of the Plan, the Administrator or Service Manager shall maintain a separate Employer Contribution Account. For each Participant described in Section 2.02 of the Plan, the Administrator or Service Manager shall maintain a separate Employee Contribution Account. The Administrator shall have full power to invest the Accounts of the Plan in accordance with section 145.11 of the Ohio Revised Code. Interest or other earnings shall be credited to each Participant's Accounts at a rate and frequency to be determined by the Trustees.

5.02 Statements of Accounts. When a Participant commences receipt of Medical Benefits under the Plan, a written statement of the status of each Participant's Account shall be furnished by the Administrator or Service Manager within thirty (30) days after the end of each Plan quarter. Participant statements shall be deemed to have been accepted by the Participant as

correct unless written notice to the contrary is received by the Service Manager within sixty (60) days after the mailing or distribution of a statement to the Participant.

5.03 Quarterly Reports to the Administrator. A written report of the Plan Accounts shall be furnished by the Service Manager to the Administrator within thirty (30) days after the end of each Plan quarter. The Administrator may request additional reports from the Service Manager, in the Administrator's sole discretion.

5.04 Year End Reports. A written report shall be prepared as of December 31 of each year and submitted to the Administrator by the Service Manager within thirty (30) days thereof (and maintained on file by the Administrator) showing the Accounts held under the Plan, a schedule of all receipts and disbursements, and all material transactions of the Plan during the preceding year. This report shall be in a form and shall contain other information as the Administrator deems appropriate. The Service Manager shall also provide such information to the Administrator as the Administrator deems necessary or appropriate for preparation of its annual report.

5.05 Annual Statement to Participants. On written request of a Participant, the Administrator or Service Manager shall furnish a statement of the amount to the credit of the Participant's Accounts. The Administrator or Service Manager is not required to answer more than one such request of a person in any in any one year. The Administrator or Service Manager may issue annual statements of Accounts to Participants.

5.06 Confidentiality.

(a) As used in this Section, "personal history record" means information maintained by the Administrator on an individual who is a Participant, former Participant, or Dependent that includes the address, telephone number, social security number, record of contributions, correspondence with the Administrator, or other information the Administrator determines to be confidential.

(b) The records of the Administrator shall be open to public inspection, except for the following, which shall be excluded, except with the written authorization of the individual concerned:

(1) The individual's statement of previous service and other information as provided for in section 145.16 of the Ohio Revised Code;

(2) The amount of a benefit paid to the individual;

(3) The individual's personal history record.

(c) All medical reports and recommendations required by this Plan are privileged, except that copies of such medical reports or recommendations shall be made available to the personal physician, attorney, or authorized agent of the individual concerned upon written release from the individual or the individual's agent, or when necessary for the proper administration of the Plan, to the physician assigned by the Trustees.

(d) Any Service Manager shall be bound by the provisions of this Section.

5.07 Unclaimed Accounts. An Account held hereunder that is payable and unclaimed, shall not be forfeited while the Participant is living. Following the Participant's death, the account shall be forfeited according to Section 4.02(c).
(Section 5.07 amended: 9/28/06, 7/7/13, 3/23/15)

5.08 Administrative Fees. An Administrative fee may be assessed against the Participant's Accounts in an amount to be determined by the Trustees and in circumstances determined by the Trustees.

ARTICLE VI MEDICAL BENEFITS

6.01 Description. The balance available in a Participant's Accounts under Article IV may be used solely for the purpose of funding Medical Benefits. Medical Benefits must be payments or reimbursement for health benefits as defined by Code Section 213 and excludable from income under Code Sections 105 and 106, as amended from time to time. Such benefits may be provided through reimbursement to the Participant or the Participant's Dependents for amounts expended for health benefits or through the payment or reimbursement of premiums to a medical benefit or health insurance program. Reimbursements for health benefits are limited to health benefits not provided by Social Security, Medicare, or any other medical and health insurance contracts held by the Participants, their Dependents, or the Employers, and the reimbursements may not be made for items paid by any other insurance contract or for expenses that are deductible by the Participant under any other section of the Code.

6.02 Commencement of Benefits. Medical Benefits commence for expenses incurred on or after the date the Participant satisfies the requirements of Section 2.04 of the Plan, and are subject to the suspension described in Section 2.04(b) of the Plan.
(Section 6.02 amended: 3/23/15)

6.03 Expenses. Medical Benefits are payable for expenses incurred by the Participant or the Participant's Dependents or, after the Participant's death, the Participant's Dependents.

6.04 Payment of Benefits. Insurance premium payments may be paid by the Administrator or Service Manager directly to insurance companies, health maintenance organizations or preferred provider organizations or to the Employer for COBRA benefits, or may be reimbursed directly to the Participant or Dependent. Payments for Medical Benefits may be made directly to the service provider, or reimbursed to the Participant. Reimbursements shall be made in accordance with rules and regulations established by the Administrator from time to time, and may require direct deposit to a financial institution for payments reimbursed to the Participant.
(Section 6.04 amended: 3/23/15)

6.05 Source of Benefits. The liability of the Plan, Employers, Administrator, Trustees, and the Trust to any Participant or Dependent for Medical Benefits under the Plan shall

be limited to the amount available for Medical Benefits in such Participant's Accounts pursuant to Section 4.01 of the Plan. The State of Ohio, its agencies, Employers, the System, and the Trustees, and their officers, employees, and contractors shall not be responsible for any Medical Benefits under the Plan.

6.06 Termination of Benefits. All Medical Benefits will terminate when the Participant's Accounts have no funds remaining. Notwithstanding the above, after the death of the Participant's last Dependent, any funds then remaining in the Participant's Accounts shall be forfeited in accordance with Article IV.

ARTICLE VII CLAIMS PROCEDURE

7.01 Payment of Medical Benefits. The Participant (or, in the event of the Participant's death, the Dependents) shall, with respect to any Medical Benefit, direct the Service Manager, as appropriate:

- (a) To pay funds from the Participant's Accounts directly for qualified health coverage;
- (b) To pay funds to the Employer for qualified COBRA premium payments;
- (c) To pay funds from the Participant's Accounts directly to health care providers for payment of qualified medical expenses;
- (d) To pay funds from the Participant's Accounts to the Participant for reimbursement of qualified medical expenses and/or premiums; or
- (e) Any combination of (a), (b), (c), or (d).

7.02 Claims Procedure.

(a) When a Participant or his or her Dependents (referred to in this Section as the "claimant") believes he or she is entitled to receive Medical Benefits under the Plan, the claimant shall deliver a claim for such benefit in writing to the Service Manager. The Service Manager shall review the claimant's request for a Plan benefit and shall thereafter notify the claimant of its decision.

(b) If the claimant's request for Medical Benefits is approved by the Service Manager, it shall notify the claimant of such approval and proceed with the distribution of such Medical Benefits to the entity as requested by the claimant within thirty (30) days after receipt of the claim for benefits.

(c) If the claimant's request for Medical Benefits is denied, in whole or in part, by the Service Manager, the Service Manager shall provide the claimant with written notice of its decision, in accordance with paragraph (d) of this Section, within thirty (30) days from the date the claimant's request for Medical Benefits was received by the Service Manager, unless special

circumstances require an extension of time for review of said claim. In the event special circumstances require an extension of time for review of the claimant's request for Medical Benefits, the Service Manager shall, prior to the expiration of the initial thirty (30) day period referred to above, provide the claimant with written notice of the extension and of the special circumstances which required such extension and of the date by which the Service Manager expects to render its decision. In no event shall such extension exceed a period of sixty (60) days from the date of the expiration of the initial period.

(d) If the claimant's request for Medical Benefits is denied, in whole or in part, by the Service Manager, the Service Manager shall notify the claimant of such denial within the time period set forth in paragraph (c) of this Section and shall include in such notice, set forth in a manner calculated to be understood by the claimant, the following:

- (1) The specific reason or reasons for the denial;
- (2) Specific reference to pertinent Plan provisions or Internal Revenue Service rules and regulations on which the denial is based;
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) Appropriate information as to the steps to be taken if the claimant wishes to submit his claim for review pursuant to Section 7.03 below.

(e) In the event written notice of a denial of a claim for Medical Benefits is not provided the claimant in the manner set forth in paragraph (d), the claim shall be deemed denied as of the date on which the Service Manager's time period for rendering its decision expires.

7.03 Appeals Procedure.

(a) Any claimant whose request for Medical Benefits has been denied, in whole or in part, or such claimant's authorized representative, may appeal said denial of Medical Benefits by submitting to the Service Manger a written request for a review of such denied claim. Any such request for review must be delivered to the Service Manager no later than sixty (60) days from the date the claimant received written notification of the Service Manager's initial denial of the claimant's request for Medical Benefits or from the date the claim was deemed denied, unless the Service Manager, upon the written application of the claimant or his authorized representative, shall in its discretion agree in writing to an extension of said period.

(b) During the period prescribed in paragraph (a) for filing a request for review of a denied claim, the Service Manager shall permit the claimant to review pertinent documents and submit written issues and comments concerning the claimant's request for Medical Benefits.

(c) Upon receiving a request by a claimant, or his or her authorized representative, for a review of a denied claim, the Service Manager shall promptly conduct an internal review of

the denied claim and shall advise the claimant of its decision within sixty (60) days from the date on which the request for review was received by the Service Manager, unless special circumstances require an extension of time for reviewing the denied claim. In the event special circumstances require an extension of time for reviewing the denied claim, the Service Manager shall, prior to the expiration of the initial 60 day period referred to above, provide the claimant with written notice of the extension and of the special circumstances which require such extension and of the date by which the Service Manager expects to render its decision. In no event shall such extension exceed a period of one hundred twenty (120) days from the date on which the claimant's request for review was received by the Service Manager. The Service Manager's decision shall be furnished to the claimant and shall:

- (1) Be written in a manner calculated to be understood by the claimant;
- (2) Include specific reasons for their decision; and
- (3) Include specific references to the pertinent Plan provisions on which the decision is based.

(d) The Service Manager may, in its discretion, determine that a hearing is required in order to properly consider the claimant's request for review of a denied claim. In the event the Service Manager determines that such hearing is required, such determination shall, in and of itself, constitute special circumstances permitting an extension of time in which to consider the claimant's request for review.

(e) The claims procedures set forth in this Article VII shall be strictly adhered to by each Participant or Dependent under this Plan, and no judicial or arbitration proceedings with respect to any claim for Plan benefits hereunder, to the extent any such proceedings may be available under applicable law, shall be commenced by any such Participant or Dependent until the proceedings set forth herein have been exhausted in full.

ARTICLE VIII TRUSTS

8.01 Trust Status. All assets held in connection with the Plan, including all contributions to the Plan, all property and rights acquired or purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in trust for the exclusive benefit of Participants and their Dependents under the Plan. Such assets shall constitute the Trust Fund. No portion of the principal and income of the Plan shall be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their Dependents and for the payment of reasonable expenses of the Plan and Trust.

8.02 Trust Fund. All amounts of compensation contributed pursuant to the Plan, all property and rights acquired or purchased with such amounts, and all income attributable to such amounts, property, or rights held as part of the Plan, shall be transferred to the Trustees to be held, managed, invested, and distributed as part of the Trust Fund in accordance with the provisions of the Plan. All contributions to the Plan must be transferred by the Employers to the

Trust Fund. All benefits under the Plan shall be distributed solely from the Trust Fund pursuant to the Plan.

8.03 Board as Trustee. The Board is the Trustee of the Trust Fund.

ARTICLE IX ADMINISTRATION OF PLAN

9.01 Compliance with Code Section 501(c)(9). At all times, the Plan shall be administered in accordance with and construed to be consistent with Code Section 501(c)(9) and its accompanying regulations.

9.02 USERRA Compliance. Notwithstanding any provision of this Plan to the contrary, contributions and benefits under the Plan with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

9.03 Trustees Duties and Powers. The Trustees shall have the authority to control and manage the operation and administration of the Plan and shall be a named fiduciary of the Plan.

(a) The Trustees shall have such power and authority (including discretion with respect to the exercise of that power and authority) as may be necessary, advisable, desirable, or convenient to enable the Trustees to carry out their duties under the Plan. By way of illustration and not limitation, the Trustees are empowered and authorized:

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

(2) To determine, consistently with the Plan, applicable law, rules, or regulations, all questions of law or fact that may arise as to the eligibility for participation in the Plan and eligibility for distribution of benefits from the Plan, and the status of any person claiming benefits under the Plan, including without limitation, Participants, former Participants, Dependents, Employees, and former Employees;

(3) To make payments from the Trust Fund to Participants, their Dependents, and other persons as the Trustees may determine;

(4) To contract with one or more Service Managers to perform education, recordkeeping, claims determinations, and administrative services under this Plan;

(5) To accept service of legal process;

(6) If a written election or consent is not specifically required by the Code, the Trustees may prescribe a verbal, electronic, or telephonic instruction in lieu of or in addition to a written form;

(7) Subject to and consistent with the Code, to construe and interpret the Plan as to administrative issues and to correct any defect, supply and omission, or reconcile any inconsistency in the Plan with respect to same;

(8) To perform any other duties or exercise any other powers granted under Chapter 145. of the Ohio Revised Code.

(b) Any action by the Trustees which is not found to be an abuse of discretion shall be final, conclusive, and binding on all individuals affected thereby. The Trustees may take any such action in such manner and to such extent as the Trustees in their sole discretion may deem expedient and the Trustees shall be the sole and final judge of such expediency.

9.04 Advice. The Trustees may employ or contract with one (1) or more persons to render advice or consultation to it with regard to its responsibilities under the Plan.

9.05 Delegation by Trustees. In addition to the powers stated in Section 9.03, the Trustees may from time to time delegate to an individual, committee, or organization certain of its fiduciary responsibilities under the Plan. Any such individual, committee, or organization shall remain a fiduciary until such delegation is revoked by the Trustees, which revocation may be without cause and without advance notice. Such individual, committee, or organization shall have such power and authority with respect to such delegated fiduciary responsibilities as the Trustees have under the Plan.

9.06 Fiduciary Insurance. The Trustees may require any of the fiduciaries described in Section 9.05 to purchase fiduciary liability insurance to cover liability or losses occurring by reason of the act or omission of such fiduciary.

9.07 Payment of Benefits. If in doubt as to the correctness of its action in making a payment of a benefit, the Administrator or Service Manager may suspend payment until satisfied as to the correctness of the payment or the person to receive the payment. In addition, the Administrator or Service Manager may file, in any state court of competent jurisdiction, a suit, in such form as it considers appropriate, for legal determination of the benefits to be paid or the persons to receive them. The Administrator or Service Manager shall comply with the final order of the court in any such suit and the Participants, Dependents, Administrator and Service Manager shall be bound thereby insofar as such order affects the benefits payable under this Plan or the method or manner of payment.

9.08 Correction of Errors. If any contributions to the Trust are determined to have been made in error, as being not authorized by either the terms of this Plan or the applicable provisions of the Ohio Revised Code, the Trustees shall have the authority to redirect any such improper contributions as necessary to correct such errors, including the refund of such contributions to the contributing Employer or Participant. However, contributions which have been made to the Trust may not be deposited in the account under Code Section 401(h) for the Defined Benefit Plan.

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

9.10 Service Manager. If the Trustees decide to contract with a Service Manager to perform recordkeeping and administrative services, the System shall provide the Service Manager with all necessary Account information, and the Service Manager shall be responsible for keeping appropriate Account records, including the crediting of interest and debiting of disbursements. The Service Manager shall submit all eligible benefit claims to the Administrator, for which the Administrator shall transmit appropriate funds for payment.

9.11 Information. To enable the Administrator to perform its functions, the Employers shall supply the Administrator with full and timely information on all matters relating to Employer Contributions on behalf of a Participant. The Administrator shall maintain such information and advise the Trustees of such other information as may be pertinent to the administration of the Trust.

9.12 Payment of Expenses. All expenses of administering the Plan shall be paid by reasonable reductions of investment earnings, forfeitures, and/or assessments from the Participant's Accounts, allocated in a nondiscriminatory manner among similarly situated employees, as determined by the Trustees from time to time. The System, Trustees, Employers, and the State, and their agencies, officers, employees, or contractors, shall not be responsible for any such expenses.

9.13 Funding Policy & Procedures. The Trustees shall formulate policies, practices, and procedures to carry out the funding of the Plan, which shall be consistent with the Plan objectives and the provisions of applicable law.

9.14 Exclusive Benefit Rule. It shall be impossible for any part of the contributions under this Plan to be used for, or diverted to, purposes other than the exclusive benefit of the Participants or their Dependents.

9.15 Continuation Coverage.

(a) Definitions. For purposes of this Article, the following definitions shall apply:

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

(2) "Continuation Coverage" means the Plan coverage elected by a Qualified Beneficiary under COBRA. This coverage shall be the same as the coverage provided to similarly situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event.

(3) “Continuation Coverage Contribution” means the amount of premium contribution required to be paid by a Qualified Beneficiary for Continuation Coverage.

(4) “Covered Participant” means an Eligible Retiree covered under the Plan on the day prior to the Qualifying Event.

(5) “Group Health Plan” has the same meaning as that term is defined in COBRA and the regulations thereunder.

(6) “Qualified Beneficiary” means, except as provided in Paragraph (h) of this Section, a Spouse or Child of a Covered Participant who was covered under the Plan on the day prior to the Qualifying Event. The term Qualified Beneficiary shall include a Child who is born to, adopted by, or placed for adoption with the Covered Participant during a period of Continuation Coverage.

(7) “Qualifying Event” means, except as provided in Paragraph (h) of this Section, the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

- i. The death of a Covered Participant;
- ii. The divorce or legal separation of the Covered Participant from his Spouse dependent; or
- iii. A Child ceasing to be eligible as a Dependent under the terms of the Plan.

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

(c) Notification of Qualifying Event. If the Qualifying Event is divorce, legal separation or a non-spouse Dependent’s ineligibility under the Plan, the Qualified Beneficiary must notify the System of the Qualifying Event within 60 days of the event in order for coverage to continue. Failure to make timely notification will terminate the Qualified Beneficiary’s right to Continuation Coverage under this Section 9.15.

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

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

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

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

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

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

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

(g) Payment of Continuation Coverage Contribution.

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

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

(3) Without further notice from the System, the Qualified Beneficiary must pay the Continuation Coverage Contribution by the first day of the month for which coverage is to be effective. If payment is not received by the System within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with Paragraph (e)(1) of this Section.

(4) No claim will be payable under this provision for any period for which the Continuation Coverage Contribution is not received from or on behalf of the Qualified Beneficiary by the due date specified in this Section 9.15(g).

(h) Bankruptcy under Title XI.

(1) For purposes of this Section only:

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

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

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

(3) Continuation Coverage for a Qualified Beneficiary who is an Eligible Retiree will continue for the life of the Eligible Retiree. When the Eligible Retiree dies, his Qualified Beneficiaries may elect to continue coverage for up to 36 additional months.

(4) If a surviving Spouse and Child(ren) are covered as Qualified Beneficiaries of a deceased Eligible Retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving Spouse. Upon the death of the surviving Spouse, the Continuation Coverage terminates.

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

(Section 9.15 enacted: 3/23/15)

ARTICLE X AMENDMENT AND TERMINATION

10.01 Amendments.

(a) Subject to the provisions of any applicable law, a majority of the Trustees may at any time amend or modify this Plan without the consent of the Employers or Participants (or any Beneficiaries thereof). Any modification, alteration, or amendment of the Plan, made in accordance with this Section, may be made retroactively if deemed necessary or appropriate by

the Trustees. A certified copy of the resolution of the Trustees making such amendment shall be delivered to the System, and the Plan shall be amended in the manner and effective as of the date set forth in such resolution. The Trustees and all Employers, Employees, Participants, Dependents, and all others having any interest under the Plan shall be bound thereby.

(b) If the Plan is amended or modified, the Administrator shall nonetheless be responsible for the supervision of claims submitted prior to the amendment or modifications in accordance with this Article.

10.02 Amendment for Qualification of Plan. It is the intent of the Trustees that the Plan shall be and remain a tax-exempt voluntary employees beneficiary association under Code Section 501(c)(9). The System shall promptly submit the Plan to the Internal Revenue Service for approval under the Code and all expenses incident thereto shall be borne by the System. The Trustees may make any modifications, alterations, or amendments to the Plan necessary to obtain and retain approval of the Secretary of the Treasury or the Secretary's delegate as may be necessary to establish and maintain the status of the Plan as tax-exempt under the provisions of the Code or other federal legislation, as now in effect or hereafter enacted, and the regulations issued thereunder. Any modification, alteration, or amendment of the Plan, made in accordance with this Section, may be made retroactively, if necessary or appropriate. A certified copy of the resolution of the Trustees making such amendment shall be delivered to the System, and the Plan shall be amended in the manner and effective as of the date set forth in such resolution. The Trustees and all Employers, Employees, Participants, Dependents, and all others having any interest under the Plan shall be bound thereby.

10.03 Termination of Plan. The Trustees shall have the right to terminate this Plan without prior notice, subject to any statutory requirements. In case of termination, the Trustees shall make a determination with regard to disposition of the assets, based on the following options:

- (a) A direct in-kind transfer of assets to a substantially similar 501(c)(9) trust;
- (b) A series of installment payments over a set period of the assets from the Trust attributable to this Plan to another 501(c)(9) trust; or
- (c) An immediate cash payment to another 501(c)(9) trust or another program providing medical benefits for the Participants of this Plan and their Dependents, subject to any contractual adjustments due upon such a cash out.

In the event of the cessation of contributions to the Plan and Trust, the Trustees may continue to administer the Plan and Trust until the Plan assets are exhausted. In any event, the Trustees shall work to prevent adverse consequences, such as a taxable event, to Participants in the Plan as a result of a termination with respect to these options, but does not guarantee avoidance of any such adverse consequences.

ARTICLE XI NONASSIGNABILITY

The right of an individual to a distribution, benefit, or any other right accrued or accruing to any individual, under this Plan, and all moneys, investments, and income from moneys or investments are exempt from any state tax, except the tax imposed by section 5747.02 of the Ohio Revised Code and are exempt from any county, municipal, or other local tax, except taxes imposed pursuant to section 5748.02 or 5748.08 of the Ohio Revised Code, and shall not be subject to execution, garnishment, attachment, the operation of bankruptcy or insolvency laws, or other process of law whatsoever, and shall be unassignable.

Notwithstanding the prior paragraph, the right of an individual to a distribution, benefit, or any other right accrued or accruing to any individual under this Plan shall be assignable to the extent required by the Child Support Performance and Incentive Act of 1998, pursuant to a National Medical Support Notice.

ARTICLE XII MISCELLANEOUS

12.01 Taxes. The Employers and the Administrator do not guarantee that any particular federal or state income, payroll, or other tax consequence will occur because of participation in this Plan

12.02 Entire Agreement. This Plan and the Trust, including any properly adopted amendments thereof, shall constitute the total agreement between the Employer and any Participant regarding the Plan. No oral statement regarding the Plan may be relied upon by any Participant

12.03 Conflicts. This Plan is executed and delivered in the State of Ohio. In resolving any conflict between provisions of the Plan and in resolving any other uncertainty as to the meaning or intention of any provision of the Plan, the interpretation that (i) causes the Plan and the Trust to be exempt from tax under Code Section 501(c)(9), (ii) causes the Plan and Trust to comply with all applicable requirements of the Code and/or (iii) causes the Plan and Trust to comply with all applicable Ohio statutes and rules, shall prevail over any different interpretation.

12.04 Limitation on Rights. Neither the establishment or maintenance of the Plan, any amendment thereof, nor any act or omission under the Plan (or resulting from the operation of the Plan) shall be construed:

(a) As conferring upon any Participant, Dependent, or any other person a right or claim against the Trust, any Employer, the Administrator, or the Service Manager, except to the extent that such right or claim shall be specifically expressed and provided in the Plan;

(b) As creating any responsibility or liability of the Employer for the validity or effect of the Plan;

(c) As a contract between the Employer and any Participant, Dependent, or other person;

(d) As being consideration for, or an inducement or condition of, employment of any Participant or other individual, or as affecting or restricting in any manner or to any extent whatsoever, the rights or obligations of the Employer or any Participant or other individual to continue or terminate the employment relationship at any time; or

(e) As giving any Participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or other person at any time.

12.05 Erroneous Payments. If a person who is a Participant, former Participant, or Dependent, as defined in this Plan, is paid any benefit or payment by the Administrator or Service Manager to which the person is not entitled, the benefit shall be repaid to the Administrator or Service Manager by the person. If the person fails to make the repayment, the Administrator or Service Manager shall withhold the amount due from any benefit due the person or may collect the amount in any other manner provided by law.

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

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

12.08 Governing Laws. The laws of the State of Ohio shall apply in determining the construction and validity of this Plan, with venue in the Franklin County Court with competent subject matter jurisdiction.

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

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

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

12.12 Counterparts. This Plan may be executed in one (1) or more counterparts, each of which shall constitute an original.

ARTICLE XIII HIPAA

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

(a) “Electronic Protected Health Information” shall have the same meaning as in 45 CFR section 160.103.

(b) “HIPAA” shall mean the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended by HITECH Act enacted as part of the American Recovery and Reinvestment Act of 2009, and regulations adopted thereunder, as may be amended from time to time.

(c) “Protected Health Information” shall have the same meaning as in 45 CFR section 160.103.

(d) “Summary Health Information” shall have the same meaning as in 45 CFR section 160.504(a).

13.02 Permitted and Required Uses and Disclosure of Protected Health Information. Subject to obtaining written certification pursuant to Section 13.03 of the Plan, the Plan may disclose Protected Health Information to the System as Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

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

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

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

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

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

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

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

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

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

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

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

(i) If feasible, return or destroy all Protected Health Information received from the Plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

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

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

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

13.04 Certification of Plan Sponsor. Except for Summary Health Information and enrollment and disenrollment information, the Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR section 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 13.02.

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

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

13.07 Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only allow access to Protected Health Information or Electronic Health Information by the healthcare administrative staff who have a role in administration of the Plan. Such employees shall only have access to and use such Protected Health Information or Electronic Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that such employee does not comply with the provisions of this Section 13.06, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. The Plan Sponsor shall implement reasonable and appropriate security measures to limit access to Electronic Protected Health Information and Protected Health Information to the appropriate healthcare administrative staff.

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

13.09 Terms. Any term used in this Article XIII shall have the meaning set forth in HIPAA and guidance issued thereunder
(Article XIII enacted: 3/23/15)