

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO

WELLNESS RETIREE MEDICAL ACCOUNT PLAN

Established Jan. 1, 2007
Includes Amendments Adopted Jan. 1, 2017

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WITNESSETH:

WHEREAS, the Public Employees Retirement System of Ohio (the “System”) desired to establish a retiree medical account on behalf of certain retirees for purposes of administering a wellness program and other health care allowances;

WHEREAS, the System was and is authorized by Section 145.58 of the Ohio Revised Code to establish a program under which funds are provided to Participants and their Dependents for the payment of health, medical, hospital, surgical, dental, or vision care expenses, including insurance premiums, deductible amounts, or copayments;

WHEREAS, the System established the Plan pursuant to the adoption of certain rules within Chapter 145-4 of the Ohio Administrative Code and now memorializes the same in this plan document; and

WHEREAS, that the Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and the Qualifying Medical Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants’ gross income under Code sections 106 and 105(b); and

WHEREAS, the reimbursements under this Plan shall be paid from the trust established by the OPERS TR Agreement for Funding Employee Benefit Plans (the “Trust”) under Section 115 of the Internal Revenue Code (“Code”) or such other funding vehicle or mechanism established by the System.

NOW THEREFORE BE IT RESOLVED, effective January 1, 2017, the System hereby adopts this plan document as the Public Employees Retirement System of Ohio Wellness Retiree Medical Account Plan (the “Plan”).

ARTICLE I
DEFINITIONS

- 1.1 “Administrator” shall mean the Board.
- 1.2 “Board” shall mean the Public Employees Retirement Board, as established by section 145.04 of the Ohio Revised Code.
- 1.3 “Code” shall mean the Internal Revenue Code of 1986, as amended, as applicable to governmental plans and applicable at such time to the Plan, and the regulations, revenue rulings, notices and other guidance promulgated thereunder.
- 1.4 “Dependent” shall mean an eligible dependent as defined in Ohio Administrative Code section 145-4-09 who is considered a dependent for purposes of Code sections 105 and 106.
- 1.5 “Electronic Protected Health Information” shall have the same meaning as in 45 CFR section 160.103.
- 1.6 “Employee” shall mean a public employee, as defined in section 145.01 of the Ohio Revised Code.
- 1.7 “Employer” shall have the same meaning as set forth in section 145.01 of the Ohio Revised Code.
- 1.8 “Health Flexible Spending Account” shall mean a health flexible spending arrangement as defined in Prop. Treasury Regulation section 1.125-5(a)(1).
- 1.9 “HIPAA” shall mean the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH Act enacted as part of the American Recovery and Reinvestment Act of 2009, and regulations adopted thereunder, as may be amended from time to time.
- 1.10 “HRA” shall mean the Public Employees Retirement System of Ohio Health Reimbursement Arrangement Plan.
- 1.11 “Medicare” shall mean the coverage provided under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B).
- 1.12 “Member” shall have the same meaning as set forth in section 145.01 of the Ohio Revised Code.
- 1.13 “Participant” shall mean each Retiree or Survivor Benefit Recipient who participates in this Plan as provided in Article II.
- 1.14 “Plan” shall mean the Public Employees Retirement System of Ohio Wellness Retiree Medical Account Plan as embodied herein, and as amended from time to time.

1.15 “Plan Sponsor” shall mean the System.

1.16 “Plan Year” shall mean the calendar year.

1.17 “Protected Health Information” shall have the same meaning as in 45 CFR 160.103.

1.18 “Qualifying Medical Expense” shall mean an expense incurred by a Participant or the Dependent of such Participant, for medical care as defined in Code section 213(d) (including without limitation amounts paid for hospital, doctor, dental and vision care, drugs and premiums for accident and health insurance), but only to the extent that the Participant or Dependent, is not reimbursed for the expense through insurance or otherwise (other than under this Plan). Qualifying Medical Expense shall not include (i) expenses reimbursed or reimbursable under any private, employer-provided, other insurance, or any other accident or health plan, (ii) expenses taken as a deduction on a Participant’s federal income tax return, and (iii) non-prescription medicines or drugs (other than insulin).

1.19 “Retiree” shall mean a former Member of this System who is receiving benefits pursuant to sections 145.32, 145.33, 145.331, 145.332, 145.36, 145.361, 145.37, or 145.46 of the Ohio Revised Code or any corresponding section of the Public Employees Retirement System of Ohio Combined Defined Benefit/Defined Contribution Plan established pursuant to section 145.80 to 145.98 of the Ohio Revised Code.

1.20 “Spouse” shall mean an individual who is or was legally married to a Retiree under the laws of any state and enrolled as a Retiree’s Dependent in medical coverage sponsored by the System.

1.21 “State” shall mean the state of Ohio.

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

1.23 “Survivor Benefit Recipient” shall mean a benefit recipient of this System who is receiving benefits pursuant to section 145.45 or 145.46 of the Ohio Revised Code or any corresponding section of 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.

1.24 “System” shall mean the Public Employees Retirement System of Ohio.

1.25 “Third Party Administrator” shall mean the individual or entity appointed by the Administrator to perform third party administrative services for the Plan.

1.26 “Wellness RMA” shall mean the notional account maintained by the Administrator for a Participant in the Plan.

ARTICLE II

PARTICIPATION AND ELIGIBILITY

2.1 Eligibility for Participation.

(a) Retiree Participant. Each Retiree who, in a prior Plan Year, participated in a wellness program that was integrated with medical coverage sponsored by the System, or who received an excess allowance towards the this Plan, and maintains a balance in the Wellness RMA is a Participant in this Plan. Each Retiree whose Spouse earned a wellness incentive or excess allowance as described in this Section 2.1 is also a Participant in this Plan

(b) Spouse Participant. Each Survivor Benefit Recipient who, in a prior Plan Year, participated in a wellness program that was integrated with medical coverage sponsored by the System, or who received an excess allowance towards the this Plan, and maintains a balance in the Wellness RMA is a Participant in this Plan.

2.2 Enrollment in the Plan. New enrollments to this Plan are not currently permitted. New Wellness RMAs may be established after January 1, 2017 only if the Participant earned a wellness incentive due to a wellness activity commenced prior to January 1, 2017.

2.3 Exclusions from Participation. Persons who are not already Participants in this Plan as described in Section 2.1 and 2.2 are excluded from participation in this Plan.

2.4 Termination of Participation. Except as provided in Article VI, a person shall cease to be a Participant on the earlier of: (i) the date the Wellness RMA is exhausted; (ii) the Participant's date of death; (iii) the month a Participant becomes a participant in the HRA; (iv) the date a Participant is employed or re-employed as an Employee of the Employer; or (v) the date on which this Plan is terminated by the System. Reimbursements from the Participant's Wellness RMA after termination of the Participant's participation shall be governed by Article IV.

ARTICLE III

FUNDING OF WELLNESS RMA

3.1 **System's Source of Funding.** The coverage under this Plan shall be funded by and paid from a trust established under Code Section 115 or any such other funding vehicle or mechanism established by the Board on behalf of eligible Retirees and eligible Survivor Benefit Recipients. Nothing herein will be construed to require the System or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the System from which any payment under this Plan may be made. A Wellness RMA has been established for each eligible individual that satisfies the requirements of Sections 2.1 and 2.2. In no event shall coverage under this Plan be funded with Participant contributions.

3.2 **Eligibility for Prior Wellness Incentives and Excess Allowance.**

(a) **Prior Wellness Incentives.** In prior Plan Years, a Retiree, Spouse, or Survivor Benefit Recipient who participated in a wellness program sponsored by the System received notional credits in the Participant's Wellness RMA.

(b) **Excess Allowances.** In prior Plan Years, the System granted notional allowance amounts to Retirees, Spouses (credited to the Retiree) and Survivor Benefit Recipients as a credit towards the monthly premium for health care coverage sponsored by the System. If the individual selected coverage that cost less than the monthly allowance, the System made a notional credit of the difference in allowance and premium to the Participant's Wellness RMA.

(c) The System does not currently provide wellness program incentives or excess allowances in relation to this Plan.

(d) In the event a married Participant's Spouse is also a Participant in this Plan, then each such Participant shall be considered an unmarried Participant.

ARTICLE IV
REIMBURSEMENTS

4.1 Reimbursements for Participants.

(a) Beginning on the first date on which an individual becomes a Participant in this Plan, the Plan will reimburse a Participant for Qualifying Medical Expenses, not to exceed the balance in the Wellness RMA. A Participant shall be entitled to reimbursement under this Plan only for Qualifying Medical Expenses incurred after such individual becomes a Participant in this Plan and before his or her participation has ceased.

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

4.2 Reimbursement of Qualifying Medical Expenses. The Administrator shall reimburse a Participant for Qualifying Medical Expenses, up to the unused amount in the Wellness RMA. The Wellness RMA is closed when the maximum amount available for reimbursement has been issued. In order to receive the reimbursement, the Participant or authorized representative must submit a written application in accordance with Section 4.4. Reimbursement of Qualifying Medical Expenses from a Wellness RMA shall be notionally debited from the respective Wellness RMA as of the date of and in the amount(s) disbursed from this Plan. The Administrator shall reimburse a Participant for the amount of the approved Qualifying Medical Expenses by direct deposit to the Participant's account with an appropriate financial institution, as determined by the Administrator. The Administrator shall reimburse a Participant by check if the direct deposit account of the Participant is unknown to the System. Any Wellness RMA reimbursement payment that is unclaimed by the Participant within ninety (90) days from the date of the reimbursement payment shall expire; provided, however, the Administrator shall reissue the Wellness RMA reimbursement payment to the individual upon the individual's request. Amounts not reissued remain in the Wellness RMA and are treated consistent with the Plan regarding termination and death.

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

4.4 Claims for Reimbursement of Qualifying Medical Expenses.

(a) Timing. Subject to Article V, a Participant may apply to the Administrator for reimbursement of Qualifying Medical Expenses by submitting a written application to the Third Party Administrator, or by following the reimbursement procedures established by the Third

Party Administrator. The Third Party Administrator shall reimburse the Participant for expenses that it determines are Qualifying Medical Expenses, up to the balance in the Wellness RMA.

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

- (1) The amount, less any amount recovered or expected to be recovered under any insurance arrangement or other plan with respect to the expense, the date, and the nature of the expense with respect to which reimbursement is requested;
- (2) The name of the person, provider, Insurance Carrier, organization or entity to which the expense was or is to be paid;
- (3) The name of the person for whom the expense was incurred and, if such person is not the Participant, the relationship of such person to the Participant;
- (4) In the case of premium reimbursement, the name of the insured, name of insurance carrier, date of coverage, type of coverage, amount of premium, proof of Medicare coverage.

Such application shall be accompanied by bills, invoices, insurance provider's explanation of benefits, receipts, canceled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Administrator or Third Party Administrator may request.

(c) Automatic substantiation. Insurance premium payments may be paid by the Administrator or Third Party Administrator directly to insurance companies, health maintenance organizations or preferred provider organizations or the employer for COBRA benefits, or be made directly to the service provider, or reimbursed to the Participant. The Administrator may provide directly to the Third Party Administrator substantiation of insurance premiums that were paid by the Participant to the Administrator for other types of health care coverage sponsored by the System. Reimbursements shall be made in accordance with the rules and regulations established by the Administrator from time to time.

4.5 Carryover of Wellness RMA Balance. Except as provided in Section 4.7, if any balance remains in the Participant's Wellness RMA at the end of a Plan Year, such balance shall be carried over to the immediately following Plan Year to reimburse the Participant for Qualifying Medical Expenses.

4.6 Loss of Coverage and Forfeiture of Wellness RMA.

(a) Termination of Participation Under Section 2.4(ii) - Death. Upon termination of participation as set forth in Section 2.4(ii), all coverage under this Plan shall cease unless

Participant's Dependent continues coverage under the Plan, if applicable, by electing COBRA continuation coverage pursuant to Article VI or the coverage provided under the Plan pursuant to Section 4.7(a)(1).

(b) Termination of Participation Under Section 2.4(iii) – Participation in HRA. Upon termination of participation as set forth in Section 2.4(iii), a Participant of this Plan who is or becomes a participant in the HRA or is married to an HRA participant shall cease being a Participant in this Plan. The amount in the Participant's Wellness RMA shall be notionally credited to the Retiree's HRA when the Administrator coordinates the balance transfer with the administrator of the HRA.

4.7 Death.

(a) Participant.

- (1) Upon the death of a Participant, the deceased Participant's Dependent may waive COBRA continuation coverage and elect to continue coverage under the Plan pursuant to this Section 4.7 as alternative coverage to COBRA continuation coverage. Such Participant's Dependent(s) shall be eligible to submit claims for Qualifying Medical Expenses which are incurred by such Dependent, provided the Dependent has waived COBRA continuation coverage. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's Wellness RMA determined as of the date of his or her death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third Party Administrator consistent with this Article V.
- (2) Notwithstanding Section 4.7(a)(1), an authorized representative (including the deceased Participant's Dependent) of a deceased Participant may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the Participant's death. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant's Wellness RMA determined as of the date of his or her death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third Party Administrator consistent with this Article IV.
- (3) The balance in a deceased Participant's Wellness RMA shall be forfeited upon the later of: (i) Failure of a deceased Participant's Dependent or authorized representative, as applicable, to submit to the Plan a claim for reimbursement of any Qualifying Medical Expense pursuant to Sections 4.7(a)(2) within a consecutive twenty-four (24) month period following the deceased Participant's date of death, or (ii) Failure of deceased Participant's Dependent or authorized representative, as applicable, to make a claim for reimbursement of any Qualifying Medical Expense

pursuant to Sections 4.7(a)(1) at least once within the twenty-four (24) month period following the date the most recent claim was submitted by the Dependent or authorized representative.

(b) Spouse Participant. Upon the death of a Spouse Participant, such deceased Spouse Participant's coverage shall cease and any unused amount in his or her Wellness RMA on the date of death shall be forfeited twenty-four (24) months after the date of death. An authorized representative of a deceased Spouse Participant may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Spouse Participant prior to the Spouse Participant's death. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Spouse Participant's Wellness RMA determined as of the date of his or her death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. The balance in a deceased Spouse Participant's Wellness RMA shall be forfeited upon the expiration of the twenty-four (24) month period following the date of death.

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

ARTICLE V

CLAIM PROCEDURES

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

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

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

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

- (1) The Claimant, or his or her authorized representative, whose claim has been denied shall file with the Third Party Administrator a notice of desire to appeal the denial. Such notice shall be filed within one hundred eighty (180) days of receipt by the Claimant of the adverse benefit determination by the Third Party Administrator, shall be made in writing, and shall set forth all of the facts upon which the appeal is based. Appeals not timely filed shall be barred.
- (2) A Claimant, or his or her authorized representative, shall be provided a reasonable opportunity to appeal an adverse determination with the Third Party Administrator under which there will be a full and fair review of the claim and the adverse determination. Accordingly: (i) a Claimant will be provided the opportunity to submit written comments, documents, records or other information

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

- (3) The Third Party Administrator shall consider the merits of the Claimant's written presentations, the merits of any facts or evidence in support of the denial of reimbursements, and such other facts and circumstances, as the Third Party Administrator shall deem relevant.
- (4) The Third Party Administrator shall render a determination upon the appealed claim within thirty (30) days after receipt of the Claimant's request for review, unless the Third Party Administrator determines that special circumstances require an extension of time for processing the claim, in which case the Claimant shall be give a written notification within such initial thirty (30) day period specifying the reasons for the extension and when such review shall be completed (provided that such review shall be completed within one hundred twenty (120) days after the date on which the request for review was filed). The determination shall be written in a manner calculated to be understood by the Claimant and shall include: (i) the specific reason or reasons for the determination; (ii) the specific references to the specific Plan provisions on which the determination was based; (iii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for reimbursements; (iv) a statement describing the Plan's appeals procedures; (v) the internal rule, guideline or protocol relied upon in making the adverse determination or a statement that the internal rule, guideline, or protocol may be obtained free of charge upon request; and (vi) if the adverse determination is based on a medical necessity or similar exclusion or

limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The determination so rendered shall be binding upon all parties.

- (5) The single level of appeal described in this section is mandatory before a Claimant can file legal action against the Administrator.
- (6) The Administrator has determined that due to the nature of this Plan, there will be no pre-service claims or urgent claims, and all claims and appeals under this Plan shall constitute post-service claims. Notwithstanding the foregoing, to the extent that a claim or appeal is received by the Plan that constitutes an urgent care request, a pre-service request or a concurrent claim, the time periods set forth in this Section 5.1 shall be adjusted to reflect the applicable time periods set forth in Department of Labor regulation section 2560.503-1.

5.2 Exhaustion of Administrative Remedies and Pursuit of Legal Action. The exhaustion of the claim procedure in this Article V is mandatory for resolving every claim and dispute arising under this Plan. Claimant, or his or her authorized representative may not pursue any legal action or equitable remedy otherwise available after the expiration of two (2) years from the date of the written final adverse determination as provided in Section 5.1.

ARTICLE VI

CONTINUATION COVERAGE UNDER COBRA

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

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

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

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

(d) “Covered Participant” means a Participant or Dependent covered under the Plan on the day prior to the Qualifying Event.

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

(f) “Qualified Beneficiary” means, except as provided in Section 6.8, a Spouse or Child of a Covered Participant who was covered under the Plan on the day prior to the Qualifying Event. The term Qualified Beneficiary shall include a Child who is born to, adopted by, or placed for adoption with the Covered Participant during a period of Continuation Coverage.

(g) “Qualifying Event” means, except as provided in Section 6.8, the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

- (1) The death of a Covered Participant;
- (2) The divorce or legal separation of the Covered Participant from his Spouse; or
- (3) A Child ceasing to be eligible as a Dependent under the terms of the Plan.

6.2 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 sixty- (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.

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

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

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

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

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

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

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

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

6.7 Payment of Continuation Coverage Contribution.

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

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

(c) Without further notice from the System, the Qualified Beneficiary must pay the Continuation Coverage Contribution by the first day of the month for which coverage is to be effective. If payment is not received by the System within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with Section 6.5(a).

(d) No claim will be payable under this provision for any period for which the Continuation Coverage Contribution is not received from or on behalf of the Qualified Beneficiary by the due dates specified in this Section 6.7.

6.8 Bankruptcy under Title XI.

(a) For purposes of this Section 6.8 only:

(1) "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 an Eligible Survivor Benefit Recipient or as a Spouse or Child on the day before the date of the Qualifying Event.

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

(b) If a Qualified Beneficiary experiences a Qualifying Event as defined in this Section, he may elect to continue coverage under the Plan if he pays the Continuation Coverage Contribution specified from time to time by the System, and makes his election in accordance with Section 6.2.

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

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

ARTICLE VII

PROVISION OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR

7.1 Permitted and Required Uses and Disclosure of Protected Health Information. Subject to obtaining written certification pursuant to Section 7.2 of the Plan, the Plan may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

- (a) To perform Plan administrative functions which the Plan Sponsor performs for the Plan; or
- (b) Modifying, amending, or terminating the Plan.

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

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

- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
- (b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions, conditions, and security measures that apply to the Plan Sponsor with respect to Protected Health Information or Electronic Protected Health Information, including implementing reasonable and appropriate security measures to protect electronic Protected Health Information.
- (c) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the Plan Sponsor or other entity adopting the Plan, unless the benefit plan is a health plan, as that term is defined at 45 CFR section 160.103, and is part of an organized health care arrangement which includes the Plan.
- (d) Report to the Plan any use or disclosure of a Plan Participant's Protected Health Information that is inconsistent with the uses or disclosures allowed under the Plan document of which it becomes aware.
- (e) Make available to a 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 requests an accounting of disclosures of the Participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

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

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

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

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

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

7.3 Certification of Plan Sponsor. Except for Summary Health Information and enrollment and disenrollment information, the Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR section 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 7.2.

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

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

7.6 Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only allow access to Protected Health Information or Electronic Protected Health Information by 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 7.6, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. The Plan Sponsor shall implement reasonable and appropriate security measures to limit access to Electronic Protected Health Information and Protected Health Information to the appropriate healthcare administrative staff.

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

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

ARTICLE VIII

ADMINISTRATION OF THE PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.6 Limitation on Recovery. Participants, Retirees, Survivor Benefit Recipients, Spouses and Dependents may not seek recovery against the Administrator or System, or any

employee, contractor, or agent of the Employer, Administrator, or System for any loss sustained by any Participant, Retiree, Survivor Benefit Recipient, Spouse or Dependent due to the nonperformance of their duties, negligence, or any other misconduct of the above named persons. This paragraph shall not, however, excuse fraud or a wrongful taking by any person.

8.7 Payment of Expenses. All reasonable expenses of administration of the Plan and any trust forming a part thereof shall be paid by the System. Notwithstanding the foregoing, commencing on a date determined by the System, each Participant shall be responsible for the payment of any ministerial fee imposed by the Third Party Administrator and such fee shall be deducted from the Participant's Wellness RMA. The System, Board, and Employers shall not be responsible for any such ministerial expense.

ARTICLE IX

AMENDMENT AND TERMINATION

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

9.2 Termination. Although it is the expectation of the System that this Plan will continue indefinitely, the Board shall have the right, notwithstanding any other provision contained herein, at any time to terminate this Plan. In the event of such termination, the assets of this Plan shall be dispersed in accordance with the terms of the trust.

ARTICLE X

MISCELLANEOUS

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

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

10.3 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 Third Party Administrator to which the person is not entitled, the benefit shall be repaid to the Administrator or Third Party Administrator by the person. If the person fails to make the repayment, the Administrator or Third Party Administrator shall withhold the amount due from any benefit due the person or may collect the amount in any other manner provided by law.

10.4 Guarantee of Tax Consequences. Neither the Administrator nor the System makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.5 Newborns' and Mothers' Health Protection Act of 1996. The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

10.6 Women's Health and Cancer Rights Act of 1998. To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

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

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

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

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

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

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

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

10.11 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.

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

10.13 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.

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

10.15 Construction. This Plan shall be construed:

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

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

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

IN WITNESS WHEREOF, the System has adopted this Plan this 15th day of January, 2017.

PUBLIC EMPLOYEES RETIREMENT SYSTEM
OF OHIO

By: Karen E. Carraher
Karen E. Carraher

Its: Executive Director