



Ohio Public Employees Retirement System

2019 Summary Plan Description

Health Reimbursement Arrangement Plan



SUMMARY PLAN DESCRIPTION

FOR THE

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO

HEALTH REIMBURSEMENT ARRANGEMENT PLAN

2019

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INTRODUCTION

The Public Employees Retirement System of Ohio ("System") provides a health reimbursement arrangement ("Plan") for the purpose of allowing certain retirees covered under the System to obtain reimbursement of Qualified Medical Expenses incurred by such retirees and their Dependents.

The Plan is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and a medical reimbursement plan under Code sections 105 and 106. The Qualifying Medical Expenses reimbursed under the Plan are intended to be eligible for exclusion from a Participant's gross income under Code section 105(b).

This Summary is to help you understand how the Plan works. It describes the benefits available, the advantages of a health reimbursement arrangement and the key features of the Plan. Please take the time to familiarize yourself with the contents of this Summary, and keep it for your future reference.

If you have questions about the Plan, feel free to contact the Third Party Administrator that is listed below under "**PLAN INFORMATION**."

This Summary Plan Description (the "Summary") highlights the important features of the Plan. It is not intended to give all details of the Plan. The Plan, and not this Summary Plan Description, is the official document that controls your rights, benefits and duties under the Plan. Any future revision of the Summary shall completely replace and override this Summary in all respects.

Numerous terms are capitalized and used throughout this Summary. Terms not explained when first used are explained in the back of the Summary in the section "**DEFINITION OF TERMS**".

PLAN INFORMATION

Name of the Plan

Public Employees Retirement System of Ohio Health Reimbursement Arrangement Plan.

The Plan Sponsor and Plan Administrator

The Public Employees Retirement System of Ohio, the sponsor of the Plan, is located at 277 East Town Street, Columbus, OH 43215-4642. If you have any questions of the Plan Sponsor regarding the Plan, you may contact OPERS at (614) 222-7377 or 1-800-222-PERS (7377). Its employer identification number, assigned by the Internal Revenue Service, is 31-6401653.

The Third Party Administrator

For Medicare Plan Selection and Enrollment in the Plan

The Employer has engaged the services of a Third Party Administrator to assist Participants in selecting a Medicare Plan offered through the Connector. The current Third Party Administrator is Via Benefits.

Towers Watson's Via Benefits
Participant Services
10975 S. Sterling View Drive, Suite 1A
South Jordan, UT 84095
(Toll Free) 1-844-287-9945

For Reimbursement from HRAs

The Employer has engaged the services of a Third Party Administrator to assist in the day-to-day administrative duties of the HRAs. The Third Party Administrator processes the claims for reimbursement for the HRAs. The current Third Party Administrator is PayFlex Systems USA, Inc.

PayFlex Systems USA, Inc.
Claims Address:
PayFlex Systems USA, Inc.
Flex Dept.
P. O. Box 981155
El Paso, TX 79998-1155

Customer Service (Toll Free) 1-844-287-9945
General FAX Number 1-855-321-2605
Claims FAX Number 1-855-321-2605
Website Address: payflex.com

Plan Year

The Plan Year is the calendar year (January 1 through December 31). All of the Plan's records, administrative and financial, are maintained on a Plan Year basis.

THE PURPOSE OF THE PLAN

The Plan offers each Participant the opportunity to receive reimbursement through an HRA for Qualifying Medical Expenses incurred by the Participant, the Participant's Spouse, and the Participant's Dependent(s). An HRA is established on behalf of each Participant upon enrolling in a Medicare Plan. The System intends to deposit a monthly Reimbursement Allowance to the HRA of behalf of each eligible Participant. A Participant is not required or allowed to contribute

his or her HRA. The reimbursement payments from a Participant's HRA are not includible in the Participant's gross income and consequently are not taxable to the Participant. Important details of the HRA, eligibility for the Reimbursement Allowance, and the rules regarding the reimbursement of Qualifying Medical Expenses are described under the section "**YOUR HRA**" section of this Summary.

ELIGIBILITY FOR PLAN PARTICIPATION

Eligible Persons

The Plan covers Eligible Retirees and Eligible Survivor Benefit Recipients who are eligible to enroll in Medicare Parts A and B. However, there are some persons that are not eligible to participate in the Plan as described under the section "**Ineligible Persons**" below.

If you are an Eligible Retiree, then you are eligible to become a Participant in the Plan on the later of:

- the first date that you are eligible for coverage under Medicare Parts A and B;
- the effective date of your retirement benefits under either the Ohio Revised Code (sections 145.32, 145.33, 145.331, 145.332, and 145.37) or the Combined Plan (Article IX); or
- the effective of your disability benefits under either the Ohio Revised Code (section 145.35) or the Combined Plan.

If you are an Eligible Survivor Benefit Recipient, then you are eligible to become a Participant in the Plan on the later of:

- the first date that you are eligible for coverage under Medicare Parts A and B; or
- your effective date of survivor benefits under either the Ohio Administrative Code section 145-2-51 or the Combined Plan (Article XI).

For details on how to enroll in the Plan, see the section "**ENROLLING IN THE PLAN**" below.

Ineligible Persons

The following persons are not eligible to participate in the Plan:

- Any Eligible Retiree or Eligible Survivor Benefit Recipient who is not eligible to enroll in Medicare Parts A and B;

- Any Member who is a participant in the Defined Contribution Plan;
- Any age or service retiree of the Defined Benefit Plan or Combined Plan who does not satisfy the definition of Eligible Retiree;
- Any Eligible Retiree or Eligible Survivor Benefit Recipient who is employed or re-employed as an Employee of an Employer;
- Any disability benefit recipient who does not satisfy the definition of Eligible Retiree; and
- Any recipient of a survivor benefit who does not satisfy the definition of Eligible Survivor Benefit Recipient.

ENROLLING IN THE PLAN

If you are an Eligible Retiree or an Eligible Survivor Benefit Recipient, you enroll in the Plan by enrolling in Medicare Parts A and B and enrolling in a Medicare Plan which you purchase through the Connector. Dependents may have to contact the System to establish eligibility for participation in the Plan.

Your participation in the Plan becomes effective on the effective date of your coverage under the Medicare Plan that you purchase through the Connector.

YOUR HRA

When you enroll in a Medicare Plan, an HRA is set up for you in the Plan. The HRA is a bookkeeping entry which records the additions of the Reimbursement Allowances and the subtraction of reimbursements as explained below. The System and the Plan Administrator are not required to maintain any fund or to segregate any amount for the benefit of Participants. A Participant does not have any claim, right to, or security or other interest in any fund, account or asset of the System from which reimbursement payments may be paid.

Reimbursement Allowances

The System intends, though is not required, to deposit a monthly Reimbursement Allowance to an eligible Participant's HRA on the first day of each calendar month. The dollar amount of the monthly Reimbursement Allowance is determined by the System. You may telephone the Plan Administrator or visit its website to find out the amount of your monthly Reimbursement Allowance (for the telephone number and website address, see the section "**Plan Administrator**" above). The System will also inform you of your potential Reimbursement Allowance in

advance of your Medicare Plan selection. The eligibility requirements to receive a Reimbursement Allowance are explained below.

Eligibility for a Reimbursement Allowance

A Participant must authorize direct deposit of reimbursement payments from his or her HRA to his or her account with a financial institution (such as a bank or a credit union) in order to be eligible to receive a Reimbursement Allowance. In limited circumstances, the System may permit a Participant to be exempt from this direct deposit requirement.

A Participant is eligible for a monthly Reimbursement Allowance for a calendar month if he or she satisfies the following conditions on the first day of the calendar month:

- If you are an Eligible Retiree, your Medicare Parts A and B coverage and your Medicare Plan coverage (which is purchased through the Connector) are in effect.
- If you are an Eligible Retiree and you have a Child, you will receive a Reimbursement Allowance on behalf of your Child if your Child's coverage in Medicare Parts A and B and his or her Medicare Plan (which is purchased through the Connector) are in effect.
- If you are an Eligible Survivor Benefit Recipient who is a surviving Child, you will receive a Reimbursement Allowance if your coverage in Medicare Parts A and B and your Medicare Plan (which is purchased through the Connector) are in effect.
- If you are an Eligible Survivor Benefit Recipient who is a Child or Spouse, you will receive a Reimbursement Allowance if your coverage in Medicare Parts A and B and your Medicare Plan (which is purchased through the Connector) are in effect.

Coverage in Medicare Parts A and B is considered in effect on the first day of the calendar month if the premiums for such coverage for the calendar month are paid in full on or before the last day of any grace period for such calendar month.

Coverage in a Medicare Plan is considered in effect on the first day of the calendar month if the premium for the Medicare Plan for the calendar month is paid in full on or before any grace period allowed by the Medicare Plan following the first day of such calendar month.

If you do not satisfy the requirements for a monthly Reimbursement Allowance for a calendar month, then a Reimbursement Allowance will not be deposited to your HRA for that calendar month. If the Reimbursement Allowance has been deposited and it is later determined that you were not eligible for it, the Retirement Allowance may be debited from your HRA. If you satisfy the requirements for a monthly Reimbursement Allowance for a later calendar month, then any Reimbursement Allowance will be deposited to your HRA for that calendar month.

How an HRA Works

The amount of the Reimbursement Allowance deposited to your HRA for a calendar month is available to reimburse Qualifying Medical Expenses on the first day of such calendar month. See "**Qualifying Medical Expenses**" below for details on the expenses that are eligible for reimbursement from your HRA. You may only be reimbursed for Qualifying Medical Expenses which are incurred while you are a Participant in the Plan.

You may request reimbursement of Qualifying Medical Expenses from your HRA at any time during the Plan Year. You will only be reimbursed up to the unused amount in your HRA. If the amount of any Qualifying Medical Expense for which you are requesting reimbursement is more than the unused amount in your HRA, then the amount of the Qualifying Medical Expense will be carried forward until the unused amount in your HRA is sufficient to reimburse the Qualifying Medical Expense.

Any unused amount credited to your HRA is carried over month to month and Plan Year to Plan Year and is available to reimburse Qualifying Medical Expenses.

Qualifying Medical Expenses

For purposes of your HRA, Qualifying Medical Expenses are expenses incurred by you, your Spouse, and your Dependent for "medical care" as defined in Code section 213(d) which are not reimbursed through insurance or otherwise. The following is a partial list of Qualifying Medical Expenses:

- premiums for Medicare Parts A, B and D coverage (see below for additional information),
- premiums for your Medicare Plan coverage purchased through the Connector,
- excess Medicare Part B charges,
- premiums for medical, dental and vision care plans which are not paid on a pre-tax basis through an Code section 125 plan ("cafeteria" plan),
- premiums for coverage under a long-term care plan,
- deductibles under Medicare Parts A and B, medical, dental and vision care plans,
- co-payments under Medicare, Medicare Plans, medical, dental and vision care plans,
- medical equipment,
- cosmetic surgery for reconstructive purposes,
- laser eye surgery, if it is done primarily to promote the correct function of the eye;

- physical exams,
- chiropractic services,
- insulin,
- prescription drugs (excluding any imported prescription drugs),
- podiatrist fees,
- support or corrective devices (such as orthopedic shoes),
- charges in excess of reasonable and customary charges as determined under medical, dental and vision care plans,
- uninsured dental services (excludes certain services for cosmetic purposes),
- orthodontic services,
- eye exams, eyeglasses and contact lenses,
- hearing exams and aids,
- acupuncture fee, and
- smoking cessation programs.

Reimbursement of Medicare Parts A, B, and D premiums is limited to the amounts you pay for this coverage, less the amounts that the System or other payer reimburses to you directly. If you are unsure whether your benefits already include a partial or full reimbursement of Medicare Part A premium, you should inquire with the System at 1-800-222-7377.

For purposes of your HRA, expenses incurred for non-prescription medicines or drugs (other than insulin) and COBRA continuation coverage premiums are not Qualifying Medical Expenses.

Please refer to Internal Revenue Service Publications 969 and 502 for the definition of qualified medical expenses and a list of medical expenses.

Ordering of Reimbursements from the Plan

The Plan is designed to first reimburse you for your monthly premium for your Medicare Plan coverage that you purchase on the Connector. Once your Medicare Plan premium is reimbursed for the month, then your other Qualifying Medical Expenses will be eligible for reimbursement.

If your Qualifying Medical Expenses are also eligible for reimbursement under a Health FSA, then you must use all of the money in the Health FSA for the Plan Year before you may receive reimbursement of your Qualifying Medical Expenses through your HRA.

Requesting Reimbursement

You may request reimbursement for Qualifying Medical Expenses by submitting your completed Reimbursement Form to the Third Party Administrator by either sending your Reimbursement Form to its mailing address, or by faxing your Reimbursement Form to its Claims FAX telephone number. The Third Party Administrator's mailing address and its Claims FAX telephone number are listed above under the section "The Third Party Administrator".

Reimbursement Form. You may request reimbursement for Qualifying Medical Expenses at any time by following these steps:

- You can obtain a Reimbursement Form from the Third Party Administrator's website address <https://medicare.viabenefits.com/opers>.
- On the Reimbursement Form, complete the Account Holder and Reimbursement Information sections of the Reimbursement Form. Please provide all of the requested information.
- You must sign and date the Reimbursement Form. When you sign the Reimbursement Form you are certifying (1) that the information is correct, (2) that the expenses were incurred by you, your Spouse, or your Dependent while you are a covered Participant under the Plan, and (3) that the expenses have not been and will not be reimbursed through insurance or otherwise (other than this Plan), or taken as a deduction on your income tax return for a prior tax year.
- You must attach documentation to your Reimbursement Form to verify that your expense is a Qualified Medical Expense as explained below.

Medicare Plan Premiums Documentation. For reimbursement of your Medicare Plan premiums, you must attach to your Reimbursement Form your proof of payment for your Medicare Plan. If you pay for your Medicare Plan by personal check or by automatic deduction from your checking or savings account, then you need to attach a copy of your cancelled check or your checking or savings account statement. If you pay for your Medicare Plan with your credit card, then you need to attach a copy of your credit card statement. Once your Reimbursement Form is approved for your initial reimbursement and you receive your reimbursement payment, you will be automatically reimbursed each month for your Medicare Plan premium.

In the event the amount of your Medicare Plan premium increases or decreases, then you will have to complete and submit a new Reimbursement Form with the Third Party Administrator to receive reimbursement for the increased or decreased amount of your Medicare Plan premium. From then on you will be automatically reimbursed each month for the increased or decreased Medicare Plan premium.

If you change your Medicare Plan coverage and purchase a different Medicare Plan on the Connector, then you will need to complete and submit a new Reimbursement Form for your new Medicare Plan premium and from then on you will be automatically reimbursed each month for your new Medicare Plan premium.

Out of Pocket Reimbursement Documentation. For reimbursement of out of pocket expenses such as co-payments, co-insurance, deductibles, you must attach to your Reimbursement Form supporting documents provided by the service provider (e.g., the physician, hospital or pharmacy). Your supporting documents can be an itemized bill or receipt from the service provider or the Explanation of Benefits ("EOB") that you receive from your health plan (e.g., Medicare Plan). Your supporting documentation must include the following information:

- the dollar amount of the expense,
- the dollar amount of the expense for which the patient is responsible,
- the date the expense was incurred,
- a brief description of the expense which includes:
 - the provider's name, address, phone number and professional degree or license,
 - a description of the services or supplies provided including the appropriate procedure code,
 - the details of the charges for those services or supplies, and
 - the patient's name.

If the itemized bill or receipt does not include all of the above information, then you can also attach the EOB provided by your health plan (e.g., Medicare or Medicare supplemental plan). For example, if your itemized bill shows that insurance is pending, then you would have to also attach the EOB to your Reimbursement Form. Any handwritten itemized bill or receipt must be signed by the service provider.

For prescription drugs or supplies provided by your pharmacy, you must attach the itemized receipt produced by the pharmacy that includes the following information:

- pharmacy name and address,
- date the medication or supply was dispensed,
- name of the medication or supply, and
- the dollar amount paid by the patient.

Medicare Parts A, B and D Premiums. For reimbursement of premiums for Medicare Parts A, B or D coverage you must attach to your Reimbursement Form proof of coverage, proof of the premium amount, and proof of payment of your premiums. For Medicare Parts A or D-income-related monthly adjustment amount (IRMAA) coverage you must attach to your Reimbursement Form a copy of the "Notice of Medicare Premium Payment Due" that you receive from Medicare which verifies your coverage and the premium amount. If you pay your premium by personal check you need to attach a copy of your cancelled check or checking account statement as proof of payment. If your premium is automatically deducted by Medicare through your checking or savings account, then you need to attach a copy of your checking or savings account statement as proof of payment. If you pay your premium by a credit card, then you need to attach a copy of your credit card statement as proof of payment. If you receive Social Security benefits, then your premiums for Medicare Part B coverage is deducted from your Social Security benefit payment and you need to attach a copy of your "Benefit Award Letter" issued by the Social Security Administration. For Medicare Part D, you need to attach a copy of the policy statement from your Medicare Part D provider. If it is not available to you, please contact the Third Party Administrator for more information.

Other Health Coverage Premiums Documentation. For reimbursement of premiums for other health, vision, or dental care coverage you must attach to your Reimbursement Form a copy of the documentation that you received from the third party provider of the coverage (for example, the health insurance carrier) which identifies the type of coverage and the individual covered. You must also attach a copy of the premium statement and proof of payment. If you paid the premium by personal check or by automatic deduction from your checking or savings account, then you need to attach a copy of your cancelled check or a copy of your checking or savings account statement as proof of payment. If you pay your premium by a credit card, then you need to attach a copy of your credit card statement as proof of payment. Remember, any premium paid on a pre-tax basis through a Code section 125 plan ("cafeteria plan") is not eligible for reimbursement,

When Claims Are Paid

Approved claims will be paid within 30 days after the date the claim is filed. In the event your claim is denied, in whole or in part, please refer to "**Claim Procedures**" below.

Repayment of Ineligible HRA Payment

If any Participant receives one or more payments or reimbursements from his or her HRA for expenses that are not eligible for reimbursement ("Ineligible Reimbursements"), then the Participant must repay the Plan for the amount of the Ineligible Reimbursement.

The Participant (or former Participant or any other individual that received an Ineligible Reimbursement) agrees, upon written request by the Plan Administrator or Third Party Administrator and within thirty (30) days of such written request, to fully repay the Plan Administrator for such Ineligible Reimbursement. If the Participant (or former Participant) fails

to timely repay the Ineligible Reimbursement to the Plan Administrator, then the Participant, by his or her enrollment to participate in the Plan, specifically agrees to allow the Plan Administrator to offset the amount of the Ineligible Reimbursement against the Participant's other claims for reimbursement of Qualifying Medical Expenses. If the Participant (or former Participant) fails to reimburse the Plan Administrator for an Ineligible Reimbursement, such amount will be treated the same as any other amount to which the person is not entitled and may be withheld or collected as permitted in Ohio Revised Code section 145.563.

Termination of Participation

Upon your termination of participation in the Plan, you may be eligible to continue to receive reimbursement of Qualifying Medical Expenses. The extent to which Qualifying Medical Expenses are reimbursable depends on the reason for your termination of participation in the Plan as explained under the section below "**Reimbursement of Qualifying Medical Expenses After Termination of Participation**".

WHEN YOUR PARTICIPATION IN THE PLAN TERMINATES

Your participation in the Plan terminates on the earlier of:

- first day of the calendar month you are no longer meet the definition of Eligible Retiree or Eligible Survivor Benefit Recipient;
- first day of the calendar month following your date of death;
- the date you are employed or re-employed as an Employee of the Employer;
- the first day of the calendar month following the date you are no longer eligible for coverage under Medicare Parts A and B;
- the first day of the calendar month following enrollment in other group health coverage that precludes enrollment in a Medicare Plan or coverage under Medicare Parts A and B; or
- the date that this Plan is terminated by the System.

Reimbursement of Qualifying Medical Expenses After Termination of Participation

You will continue to be eligible to receive reimbursement of Qualifying Medical Expenses if your termination of participation is because (1) you are no longer classified as an Eligible Retiree or Eligible Survivor Benefit Recipient, (2) you are no longer eligible for Medicare Parts A and B, (3) you enroll in another group health plan that prohibits enrollment in a Medicare Plan or Medicare Parts A and B, or (4) the Plan is terminated. Qualifying Medical Expenses incurred

before and after your termination of participation are eligible for reimbursement. You will only be able to be reimbursed from the unused amount in your HRA as of the date of your termination of participation. Your HRA will be debited for reimbursements of Qualifying Medical Expenses until your HRA is depleted.

If your termination of participation is due to your re-employment or employment with the Employer, then you are eligible to receive reimbursement of Qualifying Medical Expenses which are incurred prior to the date of your termination of participation in the Plan. Any unused amount in your HRA (after reimbursement of claims incurred prior to your termination in the Plan) will be forfeited on the date of your termination of participation in the Plan. If later on you resume participation in the Plan, then the forfeited amount will be restored to your HRA.

Reimbursement of Qualifying Medical Expenses Upon Death

Eligible Retiree

Upon the death of a Participant who is an Eligible Retiree, the deceased Participant's authorized representative (which may be the Participant's surviving Spouse or Dependent) may submit a claim for reimbursement of any Qualifying Medical Expenses incurred by the deceased Participant prior to his or her termination of participation in the Plan. The available HRA balance is determined as of the date of the Participant's death which will then be debited for reimbursements of Qualifying Medical Expenses.

The unused amount in the deceased Participant's HRA will be forfeited on the later of:

- The failure of the surviving Spouse, Dependent(s), or authorized representative to file a claim for reimbursement within the 24 consecutive month period following the deceased Participant's date of death, or
- The failure of the surviving Spouse, Dependent(s), or authorized representative to file a claim for reimbursement within the 24 month period following the date the most recent claim was submitted by the surviving Spouse, Dependent(s), or authorized representative.

Surviving Spouse or Dependent(s) of Eligible Retiree

A surviving Spouse or Dependent(s) who waives COBRA continuation coverage may elect an alternative to COBRA continuation coverage. The alternative to COBRA continuation coverage allows the Spouse (or Dependent(s)) to submit claims for Qualifying Medical Expenses which were incurred by the Participant through his or her date of death, and Qualifying Medical Expenses incurred by the Spouse (or Dependent(s)) until the HRA is depleted. The available HRA balance that may be used by the Spouse (or Dependent(s)) is determined as of the date of the Participant's death. It will then be debited for reimbursements of Qualifying Medical Expenses until the HRA is depleted.

The unused amount in the deceased Participant's HRA will be forfeited on the later of:

- The failure of the surviving Spouse, Dependent(s), or authorized representative to file a claim for reimbursement within the 24 consecutive month period following the deceased Participant's date of death, or
- The failure of the surviving Spouse, Dependent(s), or authorized representative to file a claim for reimbursement within the 24 month period following the date the most recent claim was submitted by the surviving Spouse, Dependent(s), or authorized representative.

A surviving Spouse or Dependent's use of the deceased Participant's HRA at least once in a 24-month period will allow the HRA to remain active for another 24 months.

Eligible Survivor Benefit Recipient

Upon the death of a Participant who is an Eligible Survivor Benefit Recipient, the Participant's coverage under the Plan terminates. Any unused amount in the deceased Participant's HRA is forfeited 24 months after the date of death. The deceased Participant's authorized representative may submit a claim for reimbursement of any Qualifying Medical Expenses incurred by the deceased Participant prior to his or her termination of participation in the Plan prior to the HRA's forfeiture (24 months following the Participant's date of death). The available HRA balance is determined as of the date of the Participant's death and will then be debited for reimbursements of Qualifying Medical Expenses. The deceased Survivor Benefit Recipient's spouse or dependents are not eligible to make dependent claims for reimbursement from the balance of such Participant's HRA.

Continuation Coverage Rights Under COBRA

COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". Your Spouse and your Child may become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

The Spouse of a Covered Participant will become a qualified beneficiary if he or she loses coverage under the Plan because of any of the following qualifying events happen:

- The Covered Participant dies; or
- Your divorce or legal separation from the Covered Participant.

The Child of a Covered Participant will become a qualified beneficiary if he or she loses coverage under the Plan because of any of the following qualifying events happen:

- The Covered Participant dies;
- The Covered Participant becomes divorced or legally separated from his or her Spouse; or
- The Child stops being an eligible a Dependent under the terms of the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When you become a Participant in the Plan, you will receive a notice that explains your COBRA rights and obligations in detail.

FUNDING

The HRA Allowances made on behalf of eligible Participants may be funded by the System through a trust established under Code section 115 or other funding vehicle. Regardless of any trust or funding vehicle established by the System, the System has no obligation or liability to maintain any fund or to segregate any amount on behalf of any Participant. The HRA is a bookkeeping entry only and does not represent assets that are actually set aside for the exclusive purpose of providing reimbursements to Participants under the Plan. A Participant does not have any claim, right to, or security or other interest in any fund, account or asset of the System from which reimbursement payments may be paid.

CLAIM PROCEDURES

Denial of Claims

If you have followed the appropriate submission procedure for the HRA as outlined in this Summary and the Plan Administrator denies all or part of your claim, you will be notified by the Plan Administrator within 30 days (or an additional 15 days, if more time is required and you are provided with a notice of extension within the initial 30 day period) of filing your claim. If an extension is necessary because you fail to provide the information necessary to decide the claim, the notice of extension will explain the additional information needed to decide the claim and you will be given at least 45 days within which to submit the requested information.

The notice denying your claim will state the following: (1) the reason your claim was denied, (2) specific references to the provisions of the Plan upon which the denial is based, (3) a description of any additional information or material necessary to review your claim and an explanation of why such material or information is necessary, (4) advise you of any internal rules, guideline, or protocol relied upon in making the adverse determination or that the protocol relied on may be obtained by you free of charge upon request, (5) provide an explanation of the scientific and

clinical judgment for the determination if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, and (6) the procedures you must take to submit your claim for appeal, including the applicable time limits.

Appeal of Denied Claim

The Plan provides for one level of mandatory appeal for denied claims. Under the appeal, you must file a written appeal with the Third Party Administrator requesting review of your denied claim. The due date for filing your written appeal is 180 days after receiving the written notice that your claim was denied. You will be given the opportunity to submit written comments, documents, records, and other information relating to the claim for reimbursements, and you shall be provided, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for reimbursements. The review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial reimbursement determination.

Within 30 days after the Third Party Administrator receives your written appeal, you will be given a written notice of the Plan Administrator's decision. The written response of the Third Party Administrator will include (1) the reasons for their decision and references to the Plan's provisions on which the decision is based, (2) specific references to the provisions of the Plan upon which the denial is based, (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for reimbursements, (4) a description of any appeal procedures offered by the Plan and your right to obtain information about such procedures, (5) advise you of any internal rules, guideline, or protocol relied upon in making the adverse determination or that the protocol relied on may be obtained by you free of charge upon request, and (6) if the adverse determination is based on 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 your medical circumstances or a statement that such explanation will be provided free of charge upon request.

Exhaustion of Administrative Remedies and Pursuit of Legal Action

The exhaustion of the claim procedure and single level of appeal for the Plan is mandatory for resolving every claim and dispute arising under this Plan. An Eligible Retiree, Eligible Survivor Benefit Recipient, Participant, Spouse, or Dependent, as applicable, 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 this claim procedure.

PLAN ADMINISTRATION

The System has 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:

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

The Plan Administrator has 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 Plan Administrator shall include, but not limited to, doing or causing to be done the following:

- 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;
- To prepare and file any reports, notifications, registrations, and other disclosures required by the Code, the Ohio Revised Code or other applicable laws;
- 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;
- To determine eligibility of Participants and other determinations required hereunder in the administration of this Plan, and to notify the Participants of the same;
- 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;
- To establish and maintain such separate accounts and accountings in respect of each Participant as may be required by the Plan;
- To prescribe procedures to be followed and the forms to be used by Participants to enroll in and submit claims pursuant to this Plan;
- To prepare and distribute information explaining this Plan and reimbursements under this Plan in such manner as the Plan Administrator determines to be appropriate;

- To request and receive from all Participants such information as the Plan Administrator determines reasonable and appropriate;
- 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;
- 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;
- 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;
- 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;
- 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
- 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.

In addition, the Plan Administrator has 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 Plan Administrator under this Plan as the Plan Administrator in its sole discretion deem appropriate, and the Plan Administrator may delegate to and otherwise allocate among such other persons as so designated by it any of the power and authority of the Plan Administrator hereunder for the operation and administration of the Plan.

If you have any questions or requests with respect to the Plan, you may contact the Plan Administrator at the Plan Administrator's address and telephone number listed above. Information regarding the Plan is also available online at the System's website address opers.org and medicare.viabenefits.com/opers.

MORE ABOUT THE PLAN

HIPAA Privacy Rights

The Plan is required to take steps to ensure that certain protected health information is kept confidential with respect to the Plan. You may receive a separate notice from the Plan Administrator that outlines its health privacy policies.

Non-Alienation

Unless otherwise required by law, the reimbursements and HRA Allowances 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. The Plan Administrator in its sole discretion may pay any reimbursement of a claim payable to a Participant directly to a third party provider of services or insurer.

Amendment or Termination of the Plan

The System has reserved the right to amend or discontinue the Plan at any time. If the Plan is discontinued, your elections will terminate.

Non-Discrimination

The Plan Administrator may adjust the amount of the HRA Allowance or limit the amounts reimbursed or paid with respect to any Participant who is a highly compensated individual (within the meaning of section 105(h)(5) of the Code), without the consent of such person, to the extent the Plan 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.

Applicable Law

The Plan shall be construed and enforced according to the laws of the State of Ohio, to the extent not preempted by any Federal law.

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 Plan 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 Plan 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 Plan 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.

Lost Participant

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such 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.

Newborn and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

If you would like more information on WHCRA benefits, call the Plan Administrator at the telephone number listed above under the section "**Plan Administrator**".

DEFINITION OF TERMS

The following definitions are used throughout this Summary:

"**Child**" is a non-Spouse Dependent who is eligible for Medicare and meets one of the following:

- The Dependent of an Eligible Retiree; or
- The Dependent who survives a Member or disability benefit.

"**Code**" is the Internal Revenue Code of 1986, as amended.

"**Combined Plan**" is 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.

"**Connector**" is the retiree health care exchange for Medicare Eligible Retirees operated by the Third Party Administrator and its subcontractors.

"**Covered Participant**" is a Retired Employee who is covered under the Plan on the day prior to the COBRA qualifying event.

"**Defined Benefit Plan**" is 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.

"**Defined Contribution Plan**" is the Public Employees Retirement System of Ohio Defined Contribution established pursuant to sections 145.80 to 145.98 of the Ohio Revised Code.

"**Dependent**" is 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.

"**Eligible Retiree**" is an individual who is eligible for Medicare and is described in one of the following:

1. An age and service retirant who is receiving benefits pursuant to sections 145.32, 145.33, 145.332, 145.37, or 145.46 of the Ohio Revised Code, or former section 145.34 of the Ohio Revised Code or section 9.03 of the Combined Plan, and who meets one of the following:
 - a. The retirant's effective date of benefits was before January 1, 2014, and the retirant had accrued at least ten (10) Years of Employer Contributions, or for

the retiree for whom eligibility is established after June 13, 1986, and the retiree, at the time of establishing eligibility, had accrued less than ten (10) Years of Employer Contributions, exclusive of credit obtained pursuant to sections 145.297 or 145.298 of the Ohio Revised Code, credit obtained after January 29, 1981, pursuant to sections 145.293 or 145.301 of the Ohio Revised Code, credit obtained after May 4, 1992 pursuant to section 145.28 of the Ohio Revised Code, and credit obtained in the Combined Plan after January 1, 2003, pursuant to sections 145.28, 145.293, or 145.301 of the Ohio Revised Code;

- b. The retiree's effective date of benefits was on or after January 1, 2014, but before January 1, 2015, and the retiree had accrued at least ten (10) Qualified Years of Employer Contributions as of his effective date of benefits; or
 - c. The retiree's effective date of benefits was on or after January 1, 2015, and the retiree had accrued at least twenty (20) Qualified Years of Employer Contributions as of his effective date of benefits.
2. A disability benefit recipient who is receiving benefits pursuant to section 145.36 or 145.361 of the Ohio Revised Code and who meets one of the following:
- a. The disability benefit recipient's effective date of the disability benefits was before January 1, 2014;
 - b. The effective date of the disability benefits was on or after January 1, 2014, and the disability benefit recipient (1) has been receiving disability benefits for less than five (5) years; (2) has been receiving disability benefits for more than five (5) years and had accrued at least twenty (20) Qualified Years of Employer Contributions at the time of the effective date for disability benefits; or (3) qualifies for federal hospital insurance benefits under the Social Security Administration on the basis of disability before the age of sixty-five.
3. An age and service retiree who is receiving a conversion retirement benefit pursuant to section 145.331 of the Ohio Revised Code and who meets one of the following:
- a. The conversion retiree's effective date of benefits under section 145.361 of the Ohio Revised Code was before January 1, 2015 and the retiree had accrued at least ten (10) Qualified Years of Employer Contributions;
 - b. The conversion retiree's effective date of benefits under section 145.361 was on or after January 1, 2015 and the retiree described in this paragraph had accrued at least twenty (20) Qualified Years of Employer Contributions or is any age and has accrued at least thirty (30) Qualified Years of Employer Contributions. The conversion retiree shall be receiving benefits pursuant to division (A) of section 145.32, section 145.33, division (A) of 145.332,

section 145.46 or former section 145.34 of the Ohio revised Code or Sections 9.01(a) and 9.03 of the Combined Plan.

- c. The conversion retirant's effective date of benefits under section 145.361 was on or after January 1, 2015 and the retirant described in this paragraph had accrued at least twenty (20) Qualified Years of Employer Contributions or is any age and has accrued at least thirty-one (31) Qualified Years of Employer Contributions. The conversion retirant shall be receiving benefits pursuant to division (B) of section 145.32, section 145.33, division (B) of 145.332 or section 145.46 of the Ohio Revised Code or Sections 9.01(b) and 9.03 of the Combined Plan.

"Eligible Survivor Benefit Recipient" is an individual who is eligible for Medicare and is receiving a survivor benefit pursuant to sections 145.45 or 145.46 of the Ohio Revised Code or Section 9.03 of the Combined Plan and who meets one of the following:

- The surviving Child recipient survived an Eligible Retiree described in 1.a. or 2.a. of the definition of Eligible Retiree, or the recipient survived a Member who, at the time of death, had accrued less than ten (10) Years of Employer Contributions, exclusive of credit obtained pursuant to sections 145.297 or 145.298 of the Ohio Revised Code, credit obtained after January 29, 1981, pursuant to sections 145.293 or 145.301 of the Ohio Revised Code, credit obtained after May 4, 1992, pursuant to section 145.28 of the Ohio Revised Code, and credit obtained in the Combined Plan after January 1, 2003, pursuant to sections 145.28, 145.293, or 145.301 of the Ohio Revised Code;
- The surviving Child recipient survived an Eligible Retiree described in 1.b. of the definition of Eligible Retiree, or the effective date of the survivor benefit was on or after January 1, 2014 but before January 1, 2015, and the recipient survived a disability benefit recipient or Member who had accrued at least ten (10) Qualified Years of Employer Contributions as of the disability benefit effective date;
- The surviving Child recipient survived an Eligible Retiree described in 1.c. of the definition of Eligible Retiree, or the effective date of the survivor benefit was on or after January 1, 2015, and the recipient survived a disability benefit recipient or Member who, as of the survivor benefit effective date, would have attained age sixty (60) and accrued at least twenty (20) Qualified Years of Employer Contributions, or had attained any age and accrued at least thirty (30) Qualified Years of Employer Contributions; or
- The surviving Spouse recipient who meets all of the following: (1) on or before January 1, 2013, the recipient was both eligible for Medicare and receiving a survivor benefit; (2) the recipient's household income is at or below a percentage of the federal poverty level, as determined by the Board; and (3) the recipient survived an Eligible Retiree or Member who accrued at least five (5) years of Qualified Employer Contributions.

"Employee" is a public employee, as defined in section 145.01 of the Ohio Revised Code.

"Employer" has the same meaning as set forth in section 145.01 of the Ohio Revised Code.

"Health FSA" is a health flexible spending arrangement as defined in Prop. Treasury Regulation section 1.125-5(a)(1).

"HRA" is the bookkeeping account maintained by the Third Party Administrator for each Participant in the Plan and to which shall be credited any monthly Reimbursement Allowance that the Participant receives under the Plan.

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

"Medicare Cost Plan" is an individual plan which supplements the benefits provided by Medicare based on reasonable cost of the services and meets the requirements of a standard Medicare Cost Plan under applicable law. A Medicare Cost Plan may or may not include Medicare Part D prescription coverage.

"Medicare Plan" is one of the following plans made available through the Connector and is purchased through the Connector:

- an individual Medicare Advantage Plan which excludes Medicare Part D prescription drug coverage (issued by an Insurance Carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- an individual Medicare Advantage Plan which includes Medicare Part D prescription drug coverage (issued by an Insurance Carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- a Medicare Supplemental Plan;
- a Medicare Cost Plan; or
- a Special Needs Plan which is purchased through the Connector.

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

"Member" has the same meaning as set forth in section 145.01 of the Ohio Revised Code.

"Participant" is any Eligible Retiree or Eligible Survivor Benefit Recipient who participates in the Plan.

"Reimbursement Allowance" is the amount credited to the Participant's HRA.

"Special Needs Plan" is an individual Medicare Advantage coordinated care plan which targets individuals with special needs, issued by an Insurance Carrier pursuant to a contract with the Centers for Medicare and Medicaid Services.

"Spouse" shall mean an individual who is legally married to a Participant as determined under the laws of the State of Ohio.

"System" shall mean the Public Employees Retirement System of Ohio.

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

"Years of Employer Contribution" and **"Qualified Years of Employer Contribution"** shall have the same meaning as provided in Ohio Administrative Code section 145-4-01.

CONCLUSION

We hope this Summary Plan Description gives you an easy-to-understand explanation of the Plan. Please keep your copy for future reference. Remember, if any conflict should arise between this Summary Plan Description and the Plan documents, the information in the actual Plan documents will be used in all cases.

Version: 1/1/19

