**Amendment One to the**
**Public Employees Retirement System of Ohio**
**Health Reimbursement Arrangement Plan**

WHEREAS, the Public Employees Retirement System of Ohio Health Reimbursement Arrangement Plan ("Plan") was originally effective October 1, 2015;

WHEREAS, the Ohio Public Employees Retirement Board, as Trustees of the Plan ("Trustees"), reserved the right to amend the Plan pursuant to Section 9.1 of the Plan;

WHEREAS, the Trustees now desire to amend the Plan;

NOW, THEREFORE, the Plan is hereby amended as follows, effective on the date executed below:

**1. Section 5.1(b) of the Plan,** describing claims procedures is hereby amended to be and read as follows:

(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 ~~two levels~~ one level of mandatory ~~appeals~~ 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) If the decision rendered by the Third Party Administrator on the first level appeal is adverse to the Claimant, the Claimant or Claimant's authorized representative may appeal the adverse first level appeal decision. An appeal of an adverse first level appeal decision must be filed with the Third Party Administrator within sixty (60) days following receipt by the Claimant of notification of the adverse first level appeal decision.~~

~~(6) The Administrator, or its designee, will review the complete record and make a final determination on the second level appeal without giving deference to the original determination or the first level appeal determination, and the Claimant will be notified of the final determination within thirty (30) days after the second level appeal is received. A second~~ The single level of appeal described in this section is mandatory before a Claimant can file legal action against the Administrator.

(5) 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 **Error! Reference source not found.** shall be adjusted to reflect the applicable time periods set forth in Department of Labor regulation section 2560.503-1.

**2. In all other respects,** the Plan shall be and remain unchanged.

IN WITNESS WHEREOF the undersigned has executed this Amendment on the date indicated:

1/1/17

Date

Karen E. Carraher, Executive Director