

Office and Professional Employees Locals 30 & 537

Health & Welfare and Retirement Trust Funds

Administered By: Benefit Programs Administration

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MEMORANDUM

TO: Participants in O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund

FROM: Board of Trustees

DATE: March 2011

RE: Change from "Grandfathered Status" to "Non-Grandfathered Status"

Recent memos sent to you indicated the Fund made changes required by the Federal Health Care Reform Act (HCRA) resulting in the removal of any medical lifetime maximum dollar limits, certain benefit specific dollar limits and the extension of the age limitation for children to 26 (unless the child had health insurance available through his/her own employment). During that period of time the Fund was able to maintain what the HCRA determined as "Grandfathered Status" which meant that other changes were not necessary. Now that a recent analysis was done by the Trust Attorney, the Trust Consultant and with the assistance of the Trust Administrator, it has been determined by the Board of Trustees that the Fund will have to transition into what the HCRA calls "Non-Grandfathered Status." A Fund that is in Non-Grandfathered status is required to make further eligibility and benefit changes as well as implementing an expanded appeals provision for its participants. To help partially offset the cost of these additional requirements the Trustees approved an increase to the Major Medical Plan's annual deductibles. Following are all of the changes:

1. Benefits

- (a) The Major Medical Plan annual calendar year deductibles are increased by \$50 for the First Health PPO (to \$350 per year) and by \$100 for non-PPO benefits (to \$700 per year).
- (b) Also under the Major Medical Plan the non-PPO emergency room copay percentage is increased from 60% to the PPO percentage of 80%.
- (c) Preventive Care Benefit Coverage for both the Kaiser benefit plan and the PPO only in the Major Medical Plan for reasonable routine and evidence-based preventive care services required under the HCRA will be provided at 100% with no copay and no deductible. The Plan will use reasonable medical management techniques to determine coverage limitations if not otherwise specified under the HCRA.

2. **Minor Change to Age 26 Limitation for Children**

The Fund will now provide coverage to children to age 26 whether or not the child has health insurance available through his/her own employment.

3. **Appeals Procedures**

(a) ***Standard External Review Process for Denied Claims***

If your claim for medical benefits is denied in an Initial Determination or Appeal Decision and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial unless the decision is based on a determination that you failed to meet eligibility requirements under the terms of the Plan. The request must be filed with the Fund within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Plan shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be

allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization (“IRO”) that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan has contracted with at least three IROs for assignments under the Plan and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request’s eligibility and acceptance for external review which will include a statement that you may submit within ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Plan within one business day. Upon receipt of the information, the Plan may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan’s internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional’s recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by

the Federal government, national or professional medical societies, boards and associations;

- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

(b) *Expedited External Review Process for Denied Claims*

If your claim is eligible for the external review process, you may request an expedited external review if:

- an Initial Determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal Appeal Decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the Appeal Decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Plan shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Plan shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Plan.

If you have any questions regarding the contents of this notice, please call the Administrative Office at (562) 463-5065 or (800) 386-4350.