★★ SUMMARY OF MATERIAL MODIFICATIONS ★★

January 2015

To All Employees and Dependents:

This Summary of Material Modifications (SMM) is an amendment to your Plan Document/Summary Plan Description (SPD) booklet, which was effective January 1, 2012, to formalize language incorporating recent Trustee actions regarding your Plan.

The following provisions will become effective January 1, 2015, and will apply to all eligible Class "A" Active Employees and Dependents. The new or modified language, which will be added to or eliminated from your existing SPD, is shown in italics.

IMPORTANT NOTICE REGARDING GRANDFATHERED STATUS:

This Plan will be considered a non-grandfathered plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). Questions concerning this status change can be directed to the Fund Office at: (218) 728-4231 locally, or toll-free at: 1-800-570-1012. You also may contact the Employee Benefits Security Administration, U.S. Department of labor at: 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which consumer protections do and do not apply to non-grandfathered health plans.

COMPREHENSIVE MAJOR MEDICAL BENEFITS:

Comprehensive Major Medical Benefits cover expenses related to Hospital and Health Care Professionals' services, x-ray and laboratory services, certain prescription drugs and medicines, and other covered items and services when Medically Necessary. ***(See Schedule I)***	
Deductible amount *Per Eligible Person per Calendar Year* *Per Family per Calendar Year* *All covered services are subject to the Calendar Year Deductible, unless otherwise specified.*	 *$500* *$1,000*
Coinsurance of covered expenses	*80%*
Out-of-Pocket Maximum *Per Eligible Person per Calendar Year* *Per Family per Calendar Year*	 *$4,600* *$9,200*
Plan pays 100% of covered expenses in excess of such Out-of-Pocket Maximums for the remainder of that Calendar Year. *The Comprehensive Major Medical Out-of-Pocket Maximum includes all Deductibles, Copayments, and Eligible Person's Coinsurance for Essential Health Benefits. These Out-of-Pocket Maximums are separate from and do not apply to the Preferred Provider Pharmacy Prescription Drug Benefits.*	

(over)

The following are specific provisions applicable to certain services and supplies covered under the Major Medical Benefits, payable subject to the Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximums for Essential Health Benefits and Lifetime Maximum for non-essential benefits unless otherwise specified:	
Emergency services *Sickness - Deductible waived if Hospital confinement occurs within 24 hours of visit* *Injury*	 *$100 Deductible per visit* *No separate Deductible*
Treatment of Mental Health Conditions *Mental Health Professionals and Physician Visits* *Hospital confinement* *Outpatient treatment*	 *$35 Copayment; 100% thereafter. No Deductible* *80%* *80%*
Treatment of Substance Use Disorders *Mental Health Professionals and Physician Visits* *Hospital confinement* *Outpatient treatment*	 *$35 Copayment; 100% thereafter. No Deductible* *80%* *80%*
Medical-related dental services for Dependent children	*80%*
Extended post-Hospital care - Maximum following one period of Hospital confinement	*30 days; 80%*
Surgeon's services *Preferred Provider* *Non-Preferred Provider*	 *80%* *Limited to percentage of R&C Charge for surgeon and 20% of surgical allowance for assistant surgeon*
Physician Office/Hospital Visits *Retail Clinic Visits* *Online Care Anywhere Visits* *(<u>Does not</u> include visits for optometry, chiropractic and dental services.)*	*$35 Copayment; 100% thereafter. No Deductible* *$10 Copayment; 100% thereafter. No Deductible* *$10 Copayment; 100% thereafter. No Deductible*
Chiropractic *Maximum per Eligible Person per Calendar Year*	 *16 visits; 80%*

Routine care from birth through age 25 ***(See Coverage for Preventive Health Services****)*	*100% - No Deductible*
*Routine annual physical exam, including related office visits, for Employee and Spouse (****See Coverage for Preventive Health Services****)*	*100% - No Deductible*
Bariatric Surgery	*80%*
Medically Necessary inpatient and outpatient Hospital or facility services, including Physician services (subject to prior authorization requirements stated on page I-6 of your SPD and use of a Blue Distinction Center for Bariatric Surgery as stated on page I-6 of your SPD).	
Immunizations	*100% - No Deductible*
Rehabilitative therapy *Maximum per disability* *Physical and Occupational therapy (combined benefit)* *Additional Physical and Occupational therapy combined benefit per disability (Requires prior authorization)*	 *15 visits;80%* *11 visits; 80%*
Speech therapy *Benefits for disabilities caused by stroke per disability -* *Physical and Occupational therapy (combined benefit)* *Speech therapy*	*15 visits; 80%* *25 visits* *25 visits*
Ambulance	*80%*
Infertility treatment *Maximum benefit per Eligible Person per Calendar Year (Does not count toward the Out-of-Pocket Maximum, Non-Essential Health Benefit)*	*80%* *$200*
Durable Medical Equipment	*80%*

PREFERRED PROVIDER PHARMACY PRESCRIPTION DRUG BENEFIT (See Schedule III)	
Deductible amount *Per Eligible Person per Calendar Year* *Per Family per Calendar Year*	 *$50* *$100*
Prescriptions filled at non-participating pharmacies, Sam's Club, or Wal-Mart pharmacies are not covered under this Plan.	
Retail	
Generic: Up to a 90-day supply	*10%; Minimum Copayment: $15*
Brand: 30-day supply	
Preferred	*20%; Maximum Copayment:$75*
Non-Preferred	*20%; Minimum Copayment: $35; Maximum Copayment: $150*
Mail	
Generic: 90-day supply	*10%; Minimum Copayment: $15*
Brand: 90-day supply	
Preferred	*20%; Minimum Copayment: $25; Maximum Copayment: $150*
Non-Preferred	*20%; Minimum Copayment: $70; Maximum Copayment: $300*
Specialty Pharmacy (Costco)	
Preferred Generic and Brand: 30-day supply	*20%: Maximum Copayment: $100*
Non-Preferred Generic and Brand: 30-day supply	*20% ;Maximum Copayment: $350*
Out-of-Pocket Maximum *Per Eligible Person per Calendar Year* *Per Family per Calendar Year*	 *$2,000* *$4,000*
Plan pays 100% of covered expenses in excess of such Preferred Provider Pharmacy (PPRx) Out-of-Pocket Maximums for the remainder of that Calendar Year. *The PPRx Out-of-Pocket Maximum includes all Deductibles, Copayments, and Eligible Person's Coinsurance for PPRx covered expenses. These Out-of-Pocket Maximums are separate from and do not apply to the Comprehensive Major Medical Out-of-Pocket Maximums.*	

Vision Care Benefits (See Schedule V) ***Vision care expenses incurred at Sam's Club or Wal-Mart are not covered under this Plan.***	
Eligible Persons age 18 years and older: *Vision examination (one per Eligible Person each Calendar Year); Lenses (one set per Eligible Person each Calendar Year); Frames (one set per Eligible Person each Calendar Year); and Lasik surgery* *Eligible Dependent children under age 18:* *Vision examination (one per Eligible Person each Calendar Year)* *Lenses (one set per Eligible Person each Calendar Year)* *Frames (one set per Eligible Person each 12 months)*	*80% to a maximum payment of $250 each Calendar Year. No Deductible.* *80%; No Deductible* *50%; No Deductible* *50%; No Deductible*
Benefit Waiting Period: Eligible Persons who are age 18 and older on the date in which they become eligible for benefits under this Plan will not be eligible for Vision Care Benefits until the first day of the month following 12 months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the 12-month coverage period may not be continuous coverage.	

Dental Care Benefits (See Schedule VI) **No changes other than "Benefit Waiting Period" below:**
Benefit Waiting Period: Eligible Persons who are age 18 and older on the date in which they become eligible for benefits under this Plan will not be eligible for Dental Care Benefits until the first day of the month following 12-months of coverage under this Plan. For the purpose of this Benefit Waiting Period, the 12-month coverage period may not be continuous coverage.

SCHEDULE I - COMPREHENSIVE MAJOR MEDICAL BENEFITS

Prohibition on Pre-Existing Condition Exclusions:

The Affordable Care Act prohibits pre-existing condition exclusions for all Eligible Persons.

Emergency Services:

The Affordable Care Act requires that all emergency services are covered at the in-network level of benefits even if services are obtained at an out-of-network provider.

Coverage for Routine Patient Costs Incurred by Qualified Individuals Eligible To Participate in an Approved Clinical Trial:

To the extent required by the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit, or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial. Qualified Individuals must use a PPO Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.

There are specific guidelines as to who is a "Qualified Individual," what is an "Approved Clinical Trial," and what are "Routine Patient Costs," defined as follows. The Plan's utilization review provider will review all services related to participation in a clinical trial to determine whether related services are payable by the Fund under these guidelines.

"Routine Patient Costs" include items and services typically provided under the Plan for an eligible person not enrolled in an Approved Clinical Trial. However, such items and services do not include: (a) the investigational item, device, or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

"Qualified Individual" is an eligible person who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other Life-Threatening Condition and either: (a) the referring health care professional is a participating provider and has concluded that the eligible person's participation in the Approved Clinical Trial would be appropriate; or (b) the eligible person provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

"Approved Clinical Trial" is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is:

(a) Approved or funded by one of the following:

- *(1) the National Institute of Health;*
- *(2) the Centers for Disease Control and Prevention;*
- *(3) the Agency for Health Care Research and Quality;*
- *(4) a cooperative group or center of any of the preceding entities or the Departments of Defense or Veterans Affairs;*
- *(5) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or*
- *(6) the Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.*

(b) Conducted under an investigational new drug application reviewed by the FDA; or

(c) A drug trial that is exempt from having such an investigational new drug application.

"Life-Threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

If you are recommended for participation in a clinical trial, please contact the Fund Office to determine if you satisfy the parameters for this coverage.

Nondiscrimination Provisions Against Any Health Care Provider Acting Within the Scope of His License or Certification:

To the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment, or setting for an item or service, the Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law.

Coverage for Preventive Health Services:

The Affordable Care Act requires coverage for certain preventive health services with no cost-sharing on your part ***when rendered by an in-network PPO Provider.*** *Current non-PPO Provider Plan provisions will continue to apply when such services are rendered by a non-PPO Provider. No cost-sharing means that the Plan will pay 100% with no Deductible, Copayment, or Coinsurance requirement.*

The list of recommended preventive health services under the Affordable Care Act is subject to change and may have varying effective dates for specific services. The Plan will continue to cover all the preventive services and immunizations it currently does at the current benefit design until the required effective dates. For information on whether a specific preventive service or immunization is covered at 100%, you can contact the Fund Office or visit the federal government's website at:

https://www.healthcare.gov/preventive-care-benefits/

The Plan may apply reasonable medical management techniques to determine coverage limitations, if any, in cases where the recommendations or guidelines for a recommended preventive service do not specify the frequency, method, treatment, or setting for the provision of that service.

Preventive Health Services include the following:

1. *Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).*

2. *Immunizations for routine use that have in effect, a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved.*

3. *With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.*

4. *With respect to women, additional preventive care and screenings will be covered as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, to the extent not already included in certain recommendations of the USPSFT.* ***(See chart below)***

   The current recommendations of the United States Preventive Services Task Force will be considered "current" and will be followed until new guidelines are issued for breast cancer screening, mammography, and prevention.

TYPE OF SERVICE	***DESCRIPTION AND RATIONALE***	***FREQUENCY OF SERVICES***
Well-woman visits:	*This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits if women and their providers determine they are necessary. These visits will help women and their doctors determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.*	*Annual unless more than one visit is needed to obtain all necessary services*
Gestational diabetes screening:	*This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes. It will help improve the health of mothers and babies because women who have gestational diabetes have an increased risk of developing type 2 diabetes in the future. In addition, the children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant throughout childhood.*	*Between 24 and 28 weeks of gestation and at first prenatal visit identified at high risk for diabetes*
HPV DNA testing:	*Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.*	*Beginning at 30 years of age and no more frequently than every three years*

TYPE OF SERVICE	*DESCRIPTION AND RATIONALE*	*FREQUENCY OF SERVICES*
STI counseling and HIV screening and counseling:	*Sexually-active women will have access to annual counseling on HIV and sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28% of women aged 18 to 44 years reported that they had discussed STIs with a doctor or nurse.*	*Annual*
Contraception and contraceptive counseling:	*Women will have access to all contraceptive methods that require a physician's written prescription (except OTC emergency contraceptives are covered); sterilization procedures; and patient education and counseling. These recommendations do not include abortifacient drugs.*	*As prescribed*
Breastfeeding support, supplies, and counseling:	*Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.*	*Rental charges in conjunction with each birth. Cost for purchase of electric or manual breast pumps are covered one per every five calendar years in lieu of rental costs.*
Domestic violence screening:	*Screening and counseling for interpersonal and domestic violence should be provided for all women. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women.*	*Annual*

SCHEDULE II - PREFERRED PROVIDER NETWORK

Smoking Cessation Program

The following provision is deleted:

In addition, while you are enrolled in the Stop Smoking Program, the Plan will cover prescription medications which are developed specifically to assist you in your efforts to quit smoking. Coverage for these prescription medications will be subject to the Preferred Provider Pharmacy Prescription Drug Benefits outlined on page vi. To enroll in the Stop Smoking Program, call 1-888-662-BLUE (2583).

The following provision is inserted in its place:

In addition, while you are enrolled in the Stop Smoking Program, the Plan will cover prescription medications which are developed specifically to assist you in your efforts to quit smoking. Upon a physician's written prescription, these prescription medications will be covered at a $0 Copayment through the Preferred Provider Pharmacy Drug Benefit program (Envision) at both retail network pharmacies and the mail-service pharmacy. To enroll in the Stop Smoking Program, call 1-888-662-BLUE (2583).

SCHEDULE III - PREFERRED PROVIDER PHARMACY

Contraceptive Coverage:

Contraception is one of the women's preventive care service items under the Affordable Care Act. The law applies only to contraception methods for women, not men. The Plan does not cover products available without a prescription, except emergency contraception.

The rules which allow plans to use reasonable medical management to help define the nature of the covered "preventive services" also apply to women's preventive services. Accordingly, the Plan will continue to use a "cost-sharing" benefit design for brand name contraception drugs if a generic version is available and just as effective and safe for patient use. Generic contraceptives and contraceptives for which there is no generic alternative will be covered at a $0 Copayment upon a physician's written prescription. The contraceptive methods for which the Plan currently provides coverage will continue to be covered with the changes detailed in the following paragraph.

Contraceptive medications and devices that are obtainable at the pharmacy and require a physician's written prescription will be covered under the Preferred Provider Pharmacy Prescription Drug Benefit. This includes oral and transdermal contraceptives (patch), diaphragms, and vaginal hormone rings. In addition, emergency contraceptives (for example, Plan B) will be covered.

Coverage for contraceptives that are administered or inserted by a physician, including contraceptive injections, implant systems and devices, intrauterine devices, injectable hormones, and sterilization will be covered at 100% under Comprehensive Medical Benefits.

Other Preventive Care Prescriptions:

Upon a physician's written prescription, the following prescription medications will be covered at a $0 Copayment through the Preferred Provider Pharmacy Drug Benefit program (Envision) at both retail network pharmacies and the mail-service pharmacy:

(a) over-the-counter (OTC) generic aspirin, up to 325mg once per day, to prevent cardiovascular disease for men and women age 45 and older;

(b) federal legend generic sodium fluoride for dependent children age five and younger to prevent dental cavities;

(c) OTC generic folic acid for doses of 0.4mg-0.8mg once per day for women age 55 and younger who are planning or capable of pregnancy;

(d) OTC iron supplements for dependent children up to age one to treat/prevent anemia; and

(e) OTC generic vitamin D (400IU) twice per day for men and women age 65 and older who are at an increased risk for falls.

Compound Medications:

The following provision will be deleted from the list of covered PPRx medications:

compounded medications of which at least one ingredient is a prescription legend drug

The following text will be inserted in its place:

Compound medications for eligible "'pediatric" Dependents (meaning birth to age 18), covered without prior authorization.

In addition, the following language will be added to the PPRx exclusion listing:

All compound medication prescriptions for Eligible Persons age 19 and older. If you have a medical need, and there is no FDA-approved alternative medication commercially available, your physician can provide a written statement of medical necessity to Envision for reconsideration and approval, if appropriate.

If you have received a prescription for a compound medication, you must ask your physician for a new prescription for a commercially available, FDA-approved drug before your next refill or you will be required to pay the full cost of your existing prescription.

With prior authorization and a letter of medical necessity from the prescribing physician, the Plan will continue to cover compound medications that are proven to be medically necessary, clinically acceptable, and reasonably priced.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Internal Claims Appeal Procedure Changes:

The Plan's claims review and appeal procedures for health claims will be changed to comply with new regulatory requirements as follows:

1. *The Regulations broaden the definition of "adverse benefit determination" beyond the existing Department of Labor definition to include "rescission" of coverage, except in the case of fraud or intentional misrepresentation of a material fact. The regulations define a rescission as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance only has a prospective effect. The following are not considered rescissions under the Regulations, even though retroactive:*

- *Retroactive termination to the extent attributable to failure to pay a timely premium (self-payment) towards coverage.*

- *Retroactive elimination of coverage back to the date of termination of employment, due to delays in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment.*

- *The Plan's termination of coverage retroactive to the date of a divorce.*

To clarify, this means that, in general, the Plan cannot terminate your coverage retroactively. However, the Plan may do so under the circumstances described and in other instances as may be prescribed in the Regulations. The Plan is required to provide at least 30 days advance written notice to each covered person who is affected by a rescinding of coverage before the coverage may be rescinded.

2. *The Plan must provide you, free of charge, any new or additional evidence or rationale considered, relied on, or generated in connection with an appeal. Such information will be provided as soon as possible and sufficiently in advance of the date on which notice of the Plan's final adverse benefit determination must be provided.*

3. *The Plan must ensure that all claims and appeals are adjudicated with the utmost impartiality and avoid conflicts of interest. The claims or appeals adjudicator must be independent from and impartial to the Plan.*

4. *Notices of adverse benefit determinations must include: information sufficient to identify the claim involved, including the date(s) of service; health care provider; claim amount; diagnosis, treatment and denial codes, including their corresponding meanings; a description of any standard used to determine the denial and, in the case of a final appeal determination, a discussion of the decision; and a description of the available internal and external appeal process, including information on how to initiate an appeal.*

5. *The Plan must provide all notices to Participants in a "culturally and linguistically appropriate" manner where 10% or more Participants residing in a county speak the same non-English language (however, this provision does not apply to the Plan at this time).*

6. *You will be deemed to have exhausted the internal claims review and appeal procedures with respect to a claim if the Plan fails to precisely meet the requirements of the Regulations.*

7. *The Plan must continue to cover you for a concurrent care claim for ongoing treatment pending the outcome of the internal appeal.*

8. *The Plan must process urgent care claims as soon as possible but not later than 72 hours after the receipt of the claim by the Plan.*

9. *You will be deemed to have exhausted the internal claims review and appeal procedures with respect to a claim and can seek external review or file a claim in court (unless the violation was de minimis, non-prejudicial, due to good cause or matters beyond the Plan's control, or in the context of an ongoing, good-faith exchange of information with you, and not*

reflective of a pattern or practice of noncompliance) if the Plan fails to precisely meet the requirements of the Regulations.

10. *No lawsuit or other action against the Plan may be filed after 12 months from the date the claimant has been given written notice of the decision upon appeal.*

Federal External Claims Review Process:

The Plan must implement an external review process for health claims that meets the following standards and give you written notice of your rights to an external review. The Plan must provide benefits pursuant to the IRO decision without delay and regardless of whether the Plan intends to seek a judicial review of the external review decision and unless or until there is a judicial review otherwise.

Standard External Review

Request for External Review: You may file a request for an external review within four months after the date you received notice from the Plan of a final adverse benefit determination.

Preliminary Review: The Plan must complete its preliminary review within five business days following receipt of the external review request to determine whether:

1. *You were covered under the Plan at the time the health care service or item in question was requested, or in the case of a retrospective review, if you were covered under the Plan at the time the health care service or item was provided.*

2. *The adverse benefit determination or final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan.*

3. *You have exhausted the Plan's internal appeal process, unless you are not required to do so under the appeals rules.*

4. *You have provided all the information and forms required to process an external review.*

5. *Within one business day of completing its preliminary review, the Plan will notify you in writing if:*

    - *Your request is eligible for external review.*

    - *If your request is complete, but you are not eligible for an external review, the Plan will provide you with the reasons it has been determined that you are ineligible for an external review and the contact information for the Employee Benefits Security Administration (toll-free: 1-866-444-3272).*

    - *If your request is not complete, the notice will describe the missing information and materials needed to make the request complete. You may revise your complaint if you do so within: the four-month filing period; or within 48 hours after the receipt of the notice, whichever is later.*

Referral to Independent Review Organization: If your request is eligible for external review, the matter will be assigned to an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan has contracted with three IROs and rotates external review assignments among them. The IRO will be required to:

1. *Timely notify you in writing concerning your request's eligibility and acceptance for external review, as well as information on submitting additional information.*

2. *Use legal experts, where appropriate, to make coverage determinations under the terms of the Plan.*

3. *Notify you of your right to submit additional information in writing for the IRO to consider in making its decision.*

4. *Notify the Plan of and provide to the Plan, within one day of receipt, any additional information you provide regarding your claim appeal. If the Plan reverses its denial and provides coverage or payment based on this additional information, then the external review can be terminated.*

5. *Timely review all information and documentation. In reaching its decision, the IRO will review the claim de novo and not be bound by any prior decisions or conclusions reached during the Plan's internal claims review and appeals procedures. The IRO will consider the following in reaching a decision:*

    - *your medical records;*
    - *the attending health care professional's recommendation;*
    - *reports from appropriate health care professionals and other documents submitted by the Plan, you, and your treating provider;*
    - *the terms of the Plan to ensure that any decision reached is not contrary to the Plan's terms unless the terms are inconsistent with law;*
    - *appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;*
    - *any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and*
    - *the opinion of the IRO's clinical reviewer(s) after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.*

6. *Written notice of the IRO's final external review decision to you and the Plan within 45 days after the IRO received the initial request for the external review. The IRO's decision notice will contain:*

    - *a general description of the reason for the request for external review, including the date(s) of service, the health care provider, the claim amount, 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 that were relied on in making its decision;*
- *a discussion of the principal reason(s) for its decision, including 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 either you or the Plan;*
- *a statement that judicial review may be available to the claimant; and*
- *current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.*

Maintaining Records: After the IRO reaches its final external review decision, the IRO will maintain all records of all claims and notices associated with the external review process for six years. The IRO must make all such records available for examination by you, the Plan, any state or federal oversight agency, upon request, except if such disclosure would violate state or federal privacy laws.

Reversal of Plan's Decision: The Plan, upon receipt of notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, immediately will provide coverage or payments for the claim.

Expedited External Review

Request for Expedited External Review: The Plan will allow you to make a request for an expedited external review at the time you receive:

1. *An adverse benefit determination if it involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or*

2. *A final internal adverse benefit determination if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function; or*

3. *A final internal adverse benefit determination if it concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency service, but you have not yet been discharged from a facility.*

Preliminary Review: Immediately upon receipt of a request for an expedited external review, the Plan will determine whether the request meets the reviewability requirements and send written notice to you regarding whether you are eligible for an expedited external review.

Referral to Independent Review Organization: Upon determination that a request is eligible for external review, following the preliminary review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse

benefit determination or final internal adverse benefit determination to the assigned IRO as expeditiously as possible, including but not limited to e-mail, telephone, or fax.

Review of Documents: In reaching its decision, the IRO will consider your medical records and other documents to the extent appropriate.

Notice of Final External Review Decision: The IRO will provide notice of its final expedited external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

The decision of the IRO will be binding on the Plan as well as you, except to the extent other remedies are available under federal or state law.

Please keep this SMM with your Plan Document/Summary Plan Description (SPD) booklet for future reference. If you have any questions, please call the Fund Office at (218) 728-4231, or toll-free at 1-800-570-1012.

Yours very truly,

THE BOARD OF TRUSTEES

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