Summary of Material Modifications

To: Participants

From: Victoria Kuebler, Associate Director of Human Resources

Re: Amendment to Health, Dental, Vision, Life Insurance / AD&D and Employee Assistance Program of San Diego State University

Effective January 1, 2017, San Diego State University Research Foundation has amended the Health, Dental, Vision, Life Insurance / AD&D and Employee Assistance Program of San Diego State University plans to achieve compliance with newly released federal regulations, including the revised disability claims procedures rules and wellness program rules.

This Summary of Material Modifications (SMM) supplements or modifies the information presented in your Summary Plan Description (SPD) with respect to the Plan. Please keep this SMM with your other Plan materials, including the Evidence of Coverages and SPDs.

1. **Wellness Program.** In order to comply with newly released wellness program regulations related to the acquisition of genetic information and privacy of medical information, the following provisions update the ADDITIONAL HEALTH PLAN PROVISIONS section of the SPD as follows:

Wellness Program

This Plan includes a voluntary wellness program designed to promote the health and wellbeing of covered individuals. Individuals who participate in the wellness program may receive an incentive or reward as defined by the Plan Sponsor. Participants in the wellness program should refer to the program's Benefit Documents for additional information.

The wellness program is administered in accordance with applicable federal laws, including the Americans with Disabilities Act of 1990 (ADA), GINA, and HIPAA.

Reasonable Alternative Standard. In the event this Plan includes a wellness program that requires individuals to satisfy a standard related to a health factor that is "activity-only," and it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the wellness program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, the Plan will work with you (and if you wish, with your physician) to develop another way to qualify for the reward. If the Plan includes a wellness program that requires individuals to satisfy a standard related to a health factor that is "outcome-based," you may request a reasonable alternative standard regardless of whether it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the standard.

Protections from Disclosure of Medical Information. The Plan Sponsor is required by law to maintain the privacy and security of your personally identifiable health information collected by the wellness program. In the event this Plan includes a wellness program that collects disability-related information (e.g. health risk assessment questionnaire) or requires medical exams (e.g. biometric screening, blood tests, etc.) the Plan Sponsor must provide eligible individuals with the wellness program's Privacy of Information Notice prior to enrollment, which describes the type of information that will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate in the wellness program.

Acquisition of Genetic Information. Any acquisition of genetic information under a wellness program must be reasonably designed to promote health or prevent disease and enrollment in the wellness program cannot be conditioned on the agreement by the Employee to disclose genetic information.

Any requests for a reasonable alternative standard or to obtain more information, including a copy of the Privacy of Information Notice should be directed to: Ann Billing, Benefits Manager at 619-594-2790 or abilling@foundation.sdsu.edu.

2. **Disability Claims and Appeal Procedures.** In order to update the Plan's claims and appeal procedures to comply with new requirements for disability benefit claims and appeal procedures, the following CLAIMS AND APPEAL PROCEDURES section, hereby replaces the same section in the SPD in its entirety.

CLAIMS AND APPEAL PROCEDURES

Unless otherwise specified in the Component Plan documents, insofar as such document are consistent with the provisions of ACA, ERISA and other applicable law, the procedures outlined below must be followed by Plan participants ("claimants") to obtain payment of benefits under this Plan.

For purposes of this Section, the term "Administrator" means either the issuer or the Plan Administrator depending upon the policy or plan under which the claim has been filed.

Claims Procedures under Component Plans

For purposes of all insured and self-insured welfare plan benefits, the Benefit Documents provided by the Administrator contain a detailed description of the Administrator's claims submission rules and claims appeal procedures. The Administrator will act as, or will designate, a claims administrator to decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Administrator for a review of the denied claim. The Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. Note that under certain component benefit programs you may also have the right to obtain external review (that is, review outside of the Plan).

Please refer to Appendix B for a listing of claims and claims appeals contacts, addresses and phone numbers.

Group Health Plan Claims

For purposes of group health plans subject to ERISA, there are four types of Health Claims: Non-urgent Pre-Service, Urgent Pre-Service, Concurrent, and Post-Service (Health Claims).

- **Pre-Service Claims.** A "Pre-Service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- **Pre-Service Urgent Care Claims**. A "Pre-Service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  It is important to remember that, if you need medical care for a condition which could seriously jeopardize your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.

  Further, if the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no "Pre-Service Claim." You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-Service Claim.
- **Concurrent Claims**. A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of

treatment should be reduced or terminated, or (b) you request an extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Administrator to request an extension of a course of treatment. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a Post-Service Claim.

- **Post-Service Claims**. A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Unless specifically provided for otherwise in a Component Plan or pursuant to applicable law, a Health Claim for benefits must be filed within one year of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied, unless it is shown that it was not reasonably possible to file within this time frame.

The Plan, upon receipt of a written notice of a claim, will furnish you a form for filing proof of loss. If such forms are not furnished within 15 days after notice is given, you will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Administrator in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Administrator:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the participant; and,
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administrator will determine if enough information has been submitted to adjudicate the claim. If not, the Administrator may request more information. The Administrator must receive the additional information within 45 days (48 hours in the case of Pre-Service Urgent Care Claims) from your receipt of the request for additional information. Failure to do so may result in claims being declined or benefits reduced.

Claims of a Plan Providing Disability Benefits

For purposes of a Component Plan providing disability benefits, all claims and appeals for disability benefits shall be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Timing of Claim Decisions

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing.

For all claims, except those relating to group health plans and disability claims, if a claim is wholly or partially denied, the Administrator must notify you of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan.

Extensions. This period may be extended by the Plan for up to 90 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 90-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Group Health Plan Claim Decisions

The Administrator shall notify you, in accordance with the provisions set forth below, of a denial (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following time frames:

- **Pre-Service Urgent Care Claims.** If you have provided all of the necessary information, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  If you have not followed the Plan's procedures for filing a pre-service claim, or have not provided all of the information necessary to process the claim, then the Administrator will notify you as to the failure and the proper procedures for filing the claim or the specific information needed (as applicable) as soon as possible, but not later than 24 hours after receipt of the claim. If information is missing, you will be given at least 48 hours from receipt of the notice within which to provide the specified information. You will be given at least 45 days from receipt of the notice within which to provide the specified information. The Administrator will notify you of its determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded you to provide the information.

  No Extensions. No extensions are available in connection with Pre-Service Urgent Care Claims.

- **Pre-Service Non-Urgent Care Claims**. If you have provided all of the information needed to process the claim, the Administrator will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. If an extension has been requested, the Administrator will notify you of its decision prior to the end of the 15-day extension period.

  If you have not followed the Plan's procedures for filing a pre-service claim, the Administrator will notify you as to the failure and the proper procedures for filing the claim or the specific information needed (as applicable) as soon as possible, but not later than 5 days after receipt of the claim.

  Extensions. The adverse benefit determination notification period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

  If such an extension is necessary because you have not provided all of the information needed to process the claim, the Administrator will notify you of the required information needed to file the claim. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

- **Concurrent Claims:**

  Plan Notice of Reduction or Termination**.** If the Administrator is notifying you of a reduction or termination of a course of treatment previously approved by the Plan (other than one that occurs by reason of Plan amendment or termination), the Administrator will notify you of its decision sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care**.** If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, the Administrator will notify you of its decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as you make the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If you submit the request less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care time frame.

Request by Claimant Involving Non-Urgent Care. If the Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim does not involve Urgent Care, the request will be treated as a new benefit claim and will be decided within the time frame appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

- **Post-Service Claims.** If you have provided all of the information needed to process the claim, the Administrator will notify you of its decision within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  Extensions. This period may be extended by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

  If the extension described above is necessary because you failed to submit the information necessary to decide the claim, the notice of extension must describe specifically the required information. You shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

Disability Claim Decisions

For purposes of disability plans subject to ERISA, the Administrator must notify you of a disability claims determination within 45 days after receipt of your claim.

Extensions. This period may be extended by the Plan for two additional 30-day periods provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day processing period (or prior to the end of the 30-day extension, as applicable), of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Any notice of extension will specifically explain the standards on which entitlement to a benefit is based and the unresolved issues that prevent a decision on the claim (including any additional information needed to resolve such issues). You will be given at least 45 days to provide such information.

Notice of Denial

The notice of an adverse benefit determination (Notice of Denial) shall be written or in electronic form (in compliance with ERISA regulations), or oral in the case of a Pre-Service Urgent Care claim, as long as a written or electronic notice is furnished to you within 3 days of the oral notice, and shall set forth:

- The specific reason for the adverse benefit determination;
- Specific references to the pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;
- An explanation of the Plan's claims appeals procedures; and,
- Your right to bring a civil action under ERISA Section 502(a).

For claims related to an adverse benefit determination by a group health Component Plan, the Notice of Denial shall also include:

- Specific references to the internal rule, guideline, protocol or other similar criterion on which the adverse benefit determination is based, or a statement that such criterion was relied upon in making the adverse benefit determination and notice of where and how to obtain a copy free of charge;
- An explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request;
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination, or notice of where and how to obtain a copy free of charge; and,
- For purposes of Pre-Service Urgent Care Claims, a description of the expedited review process.

For claims related to an adverse benefit determination with respect to disability benefits, the Notice of Denial must include:

- Specific references to the internal rule, guideline, protocol or other similar criterion on which the adverse benefit determination is based, or a statement that such criterion was relied upon in making the adverse benefit determination and notice of where and how to obtain a copy free of charge;
- An explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request;

For claims for disability benefits filed under this Plan on or after January 1, 2018 (or such later date provided in any disability Component Plan document, so long as compliant with applicable claims procedure regulations), the following provisions apply:

- The notice of denial also must include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with (or not) (i) the views presented by the claimant to health care and vocational experts that examined the claimant, (ii) the views of vocational experts or medical experts whose advice was obtained (whether or not relied upon), or (iii) the disability determination made by the Social Security Administration;
  - An explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request;
  - Specific internal rules, guidelines, protocols or other similar criteria on which the denial is based, or a statement that such criteria do not exist; and
  - 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 claimant's claim for benefits.
- The term "adverse benefit determination" also means any rescission of disability coverage with respect to the participant or beneficiary.

Appeals of Adverse Benefit Determinations

The Plan Administrator maintains procedures which provide you with a reasonable opportunity to appeal an adverse benefit determination and under which there will be a "full and fair review" of the claim and the adverse benefit determination. You or your duly authorized representative may:

- Request a review by providing written notice to the Administrator;
- Submit written comments, documents, records and other information relating to the claim; and,
- Upon request and free of charge, have reasonable access to and copies of all documents, records, and other information relevant to the claim.

In addition, under ACA, non-grandfathered group health plans must implement an effective internal appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;

- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes;
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

Timing of Appeals

You shall have a reasonable opportunity to appeal a claim denial to the Administrator for full and fair review provided that the Administrator receives the written appeal within the following timeframes:

- All Claims Other Than Group Health Plan Benefits and Disability Benefits: 60 days following receipt of the Notice of Denial.
- Disability Benefits Claims: 180 days following receipt of the Notice of Denial.
- Group Health Plan Benefits Claims: 180 days following receipt of the Notice of Denial. For Pre-Service Urgent Care claims, please refer to Appendix B for a listing of appeals contacts, addresses and phone numbers.

Timing of Notification of Appeals Decision

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

The Administrator shall notify you of the Plan's benefit determination on review within the following time frames:

- All Claims Other Than Group Health Plan Benefits and Disability Benefits: 60 days after receipt of the appeal. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
- Group Health Plan Claims:
  - Pre-Service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
  - Pre-Service Non-Urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
  - Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.
  - Post-Service Claims. Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Disability Benefits Claims: 45 days after receipt of the appeal. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

Appeals Decision

The decision of the Plan Administrator shall be written and shall include specific reasons for the decision, with specific references and copies of the pertinent Plan provisions or internal guideline on which the decision is based. You also have a right to bring a civil action under ERISA Section 502(a) following the denial of your appeal. If your appeal is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, you will receive an explanation of the scientific or clinical judgment applied on the benefit determination, or notice of where and how you can obtain a copy.

For claims for disability benefits submitted on or after January 1, 2018 (or such later date provided in any Component Plan document, so long as compliant with applicable claims procedure regulations):

- An appeals decision for a disability claim filed under this Plan shall also include a discussion of the decision, including an explanation of the basis for disagreeing with (or not) (i) the views presented by the claimant to health care and vocational experts that examined the claimant, (ii) the views of vocational experts or medical experts whose advice was obtained (whether or not relied upon), or (iii) the disability determination made by the Social Security Administration. Such notification shall also include an explanation of the scientific or clinical judgment for an adverse benefit determination based on a medical necessity or experimental treatment or similar exclusion or limit, or a statement that such explanation will be provided free of charge upon request, as well as specific internal rules, guidelines, protocols or other similar criteria on which the denial is based, or a statement that such criteria do not exist.
- If the Plan fails to strictly adhere to all the requirements with respect to a claim or appeal related to disability benefits, you will be deemed to have exhausted the administrative remedies available under the Plan, and will be entitled to pursue any available remedies under ERISA section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. However, the administrative remedies will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

Second Appeal

Should you receive an adverse determination of the appeal, you have the right to file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of response to the second appeal shall be made in accordance with the same guidelines as those outlined for the first appeal.

Full and Fair Review

The Plan Administrator, as Plan Fiduciary, shall take into account all comments, documents, and other information submitted by you without regard to whether the information was submitted with the original claim. For purposes of any group health plan or disability plan, review will be conducted without deference to the original determination. Such review shall be conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the original determination or a subordinate of such individual. If the decision was based in whole or in part on a medical judgment, the appeal shall be made with consultation with the appropriate independent health care professionals, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of such person. Medical or vocational experts whose advice was obtained in making the adverse benefit determination will be identified, regardless of whether such advice was relied upon in making the determination.

A non-grandfathered group health plan must provide you, free of charge, with any new or additional evidence considered by the plan in connection with the claim and the rationale behind the adverse benefit determination. Such evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond.

For disability benefit claims submitted on or after January 1, 2018 (or such later date provided in any disability Component Plan document, so long as compliant with applicable claims procedure regulations), before the Plan issues an adverse benefit determination on review with respect to disability benefits, the Plan will provide the claimant, free of charge, any new or additional evidence considered by the Plan in connection with the disability claim and any new or additional rationale behind the adverse benefit determination. Such evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond.

If 10% or more of the population residing in the county in which a non-grandfathered group health plan or disability plan claims notice or appeals decision is sent is literate only in the same non-English language, the Plan Administrator

will provide applicable notifications and assistance with filing claims and appeals in that non-English language in accordance with applicable regulations.

Group Health Plan External Review

Non-grandfathered group health plans subject to ACA must also offer you the opportunity to pursue External Review. If your internal appeal is denied, you may have the right to have the claim reviewed by an independent reviewer (IRO), not employed by the health plan, through an External Review process. This applies to claims that involve 1) medical judgment as determined by the external reviewer; or 2) a rescission of coverage.

In general, most insurers of fully-insured group health plans must comply with the applicable state External Review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners. If no state External Review process applies, the plan must follow the federal External Review process or contract with an accredited independent review organization to review external appeals on its behalf. Insurers of plans subject to the state External Review requirements must include a description of the External Review process in (or attached to) the policy, certificate, or other evidence of coverage it provides to participants, beneficiaries, or enrollees.

Self-insured plans must implement an effective External Review process that meets minimum standards established by the Department of Health and Human Services. However, a self-insured plan may voluntarily comply with an applicable state External Review process.

State and federal External Review procedures include the following minimum consumer protections:

- Allow you at least four months to file a request for External Review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
- You must be notified and allowed to submit additional information in writing to the IRO, which the IRO must consider when conducting the External Review. The IRO must allow you at least 5 business days to submit any additional information and any additional information submitted by you must be forwarded to the issuer (or plan) within one business day of receipt by the IRO.
- For a standard External Review, the IRO must provide written notice to the issuer (or plan) and the claimant of its decision to uphold or reverse the adverse benefit determination no later than 45 days after the receipt of the request for External Review. The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent other remedies are available under state or federal law).
- For an expedited External Review, the IRO must provide notice of the decision no later than 72 hours after receipt of the request for External Review (if notice of the IRO's decision is not in writing, the IRMO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).
- You may request an "expedited" External Review if the timeframe for completing an expedited internal appeal or standard External Review would seriously jeopardize your life or health or jeopardize the claimant's ability to regain maximum function, or, if a final internal benefits denial involves an admission, availability of care, continued stay, or health care item or service for which your received emergency services, but has not been discharged from a facility.
- If the IRO's decision is to reverse the plan's benefits denial, the plan must immediately provide coverage or payment for the claim (including immediate authorization or payment of benefits).

Legal Actions

All legal action commenced under the Plan shall be brought in the federal court of proper jurisdiction in the Plan Sponsor's situs state.

The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, a claimant must complete the applicable claims procedure set out in the Plan or the Component Plan (and comply with all applicable deadlines established as part thereof). Failure to properly exhaust the claims procedure will extinguish the claimant's right to file a lawsuit with respect to the claim.

- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the insurance company or the Plan shall be determined by the terms of the applicable Component Plan.
- In the case of a Component Plan that is self-insured by the Plan Sponsor, any lawsuit seeking benefits must be brought within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.

All other Plan provisions remain unchanged so long as they are consistent with these material modifications.

To obtain more information contact Victoria Kuebler, Associate Director of Human Resources

at 619-594-1087.