



Welfare Fund of Local No. One, I.A.T.S.E.

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SUMMARY OF MATERIAL MODIFICATION

To: All Participants in the Welfare Fund of Local No. One, IATSE

From: Scott Cool, Director of Fund Administration

Date: May 7, 2010

Re: **Change to the Welfare Fund of Local No. One, IATSE**

This document is a Summary of Material Modifications ("SMM") intended to notify you of an important change made to the Welfare Fund of Local No. One, IATSE ("the Plan"). Please read this SMM carefully and keep it with the copy of the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding this change to the Plan, please contact the Fund Office during normal business hours at 320 West 46th Street, 6th Floor, New York, New York, 10036, (212) 247-5225.

The Board of Trustees has determined to revise the Claims and Appeals language appearing on page 50 of the SPD by replacing it with the following, effective January 1, 2010:

THIS SECTION DESCRIBES THE PROCEDURES FOR FILING A CLAIM FOR BENEFITS FROM THE FUND. IT ALSO DESCRIBES THE PROCEDURE YOU MUST FOLLOW IF YOUR CLAIM IS DENIED IN WHOLE OR IN PART AND YOU WISH TO APPEAL THE DECISION.

CLAIM PROCEDURE

Definition of a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including filing a claim (where necessary). When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the Plan's provisions or about Plan eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim.

The claims procedures vary depending on the kind of benefit you are seeking. For benefits for which you are required to file a claim, the claim must be filed with the organization responsible for deciding your claim as specified in the following sections. You may obtain a claim form from the Fund Office or from the organization deciding your claim.

Authorized Representatives

If you are unable to complete the claim form yourself, you may designate an individual to act as your authorized representative and complete the claim form for you. A form to designate an authorized representative can be obtained from the Fund Office. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care claim (defined below) without you having to complete an authorization form.

Types of Claims

The applicable claims procedures for benefits will not only vary depending on the kind of benefit you are seeking, but also depending on whether your claim is a Pre-Service claim, an Urgent Care claim, a Concurrent Care claim, or a Post-Service claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

Important Note: All claims for benefits under CIGNA's Medicare Eligible Retirees Program are considered Post-Service claims.

For specific information on the type of claim, or if you have any questions regarding these procedures, you should contact the Fund Office or the organization responsible for deciding your claim.

Claims for CIGNA Tier I, II, III Benefits

Please note that the CIGNA booklets contain specific procedures for you to follow if you have a claim or if you wish to appeal a claim determination made by CIGNA. Please review those sections of the CIGNA booklets carefully. The procedures set forth in the CIGNA booklets are augmented by a voluntary level of appeal to the Board of Trustees of the Fund, which is available to you after you have exhausted your rights of appeal under CIGNA.

For CIGNA benefit concerns that involve a person, a service, the quality of care or contractual benefits, you should contact CIGNA's Member Services at (800) 251-0669, or write to CIGNA at the address listed below or at the address that appears on the back of your Benefit Identification Card or the explanation of benefits or claim form. Member Services will do its best to resolve your issues. If CIGNA needs more time to review or investigate a complaint of: (1) a denial of, or failure to pay, for a referral; or (2) a determination as to whether a benefit is covered under the Plan, CIGNA will get back to you on the same day. If CIGNA cannot resolve your complaint on the same day, follow the appeal procedures described below.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy will be forwarded to CIGNA's Quality Management staff for review. CIGNA will provide written acknowledgement of your concern within fifteen (15) days with the appropriate resolution information to follow in a timely manner.

Pre-Service Claims

A Pre-Service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under Tier I, II and III of the CIGNA program, certain services require pre-certification in order to be covered. You will need to follow CIGNA's pre-service rules for receiving benefits. In general, these pre-certifications will determine the medical necessity of a particular service or supply. Under CIGNA's Medicare Eligible Retirees Program, there is no pre-certification requirement.

CIGNA Claims (In-Network): For in-network CIGNA claims, your provider will make arrangements for required pre-certification, as necessary. Please review any questions you have with your provider.

CIGNA Claims (Out-of-Network): Under Tier I, II and III of the CIGNA program, there is a Pre-Admission Certification (PAC) and Continued Stay Review (CSR) for out-of-network coverage. Under the requirements of the program, there is a fifty percent (50%) penalty if you fail to pre-certify: (1) prior to your scheduled admission date; or (2) in the case of emergency, by the end of the first scheduled work day after the date of admission. In order to file a Pre-Service claim, call INTRACORP at (800) 251-0669.

For properly filed Pre-Service claims, you and/or your health care provider will be notified of a decision within fifteen (15) days from receipt of the claim unless additional time is needed. The time for response may be extended for an additional fifteen (15) days if necessary due to matters beyond the control of the organization responsible for making the claims determination, and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service claim, CIGNA will notify you of the proper procedures to be followed in filing a claim as soon as possible but not later than five (5) days after receipt of the claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the organization responsible for making the claim determination and it includes: (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a "claim" under these procedures.

If an extension is needed because CIGNA needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have forty-five (45) days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either forty-five (45) days or the date you respond to the request (whichever is earlier). CIGNA then has fifteen (15) days to make a decision on a Pre-Service claim and notify you of its determination. If your claim is denied in whole or part, you have the right to appeal the denial of your Pre-Service claim (see Appeals Procedure described below).

Urgent Care Claims

An Urgent Care claim is any claim for medical, hospital, prescription or treatment which is subject to the time period for making a Pre-Service claim determination:

- (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- (2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether or not your claim is an Urgent Care claim is determined by CIGNA applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care claim within the meaning described above, shall be treated as an Urgent Care claim.

If you improperly file an Urgent Care claim, CIGNA will notify you and/or the provider of the proper procedures to be followed in filing a claim as soon as possible but not later than twenty-four (24) hours after receipt of the claim. You (or your representative) must provide the specific information within forty-eight (48) hours after receiving the notice. Unless the claim is refiled properly, it will not constitute a "claim" under these procedures.

If you are requesting pre-certification of an Urgent Care claim, the time deadlines are different than for Pre-Service claims. CIGNA will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical emergencies, but not later than seventy-two (72) hours after receipt of the claim. The determination will also be confirmed in writing or electronically within three (3) days.

If an Urgent Care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, CIGNA will notify you and/or your doctor as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within forty-eight (48) hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than forty-eight (48) hours after the organization receives the specified information or the end of the period given for you to provide this information, whichever is earlier. If your claim is denied in whole or part, you have the right to appeal the denial of your Urgent Care claim (see Appeals Procedures described below).

Concurrent Care Claims

A Concurrent Care claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five (5) days that is reviewed at three (3) days to determine if the full five (5) days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Care claim that involves the termination or reduction of a benefit will be made by CIGNA as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Generally, if your claim is for in-network CIGNA services, your provider will make arrangements, as necessary.

Any request by a claimant to extend approved treatment will be acted upon within twenty-four (24) hours of receipt of the claim, provided the claim is received at least twenty-four (24) hours prior to the expiration of the approved treatment. If your claim is denied in whole or part, you have the right to appeal the denial of your Concurrent Care claim (see Appeal Procedure described below).

Post Service Claims (Applicable to Certain Tier I, II, III and Medicare Eligible Retiree CIGNA Benefits)

A Post-Service claim is a claim that is not a Pre-Service claim; for example, a claim submitted for payment after health services and treatment have been obtained. Claims that are Post-Service include any CIGNA claims that are not Pre-Service (including Urgent Care) or Concurrent claims. *Important Note:* All claims for CIGNA Medicare Eligible Retiree Benefits are considered Post-Service claims.

Any CIGNA Post-Service medical and hospital claims must be submitted within twelve (12) months of the date charges are incurred. If the claim is not submitted on time, it will be denied unless it is shown that written proof of loss was given as soon as was reasonably possible.

Important Note on Prescription Drug Benefits: When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. Claims must be submitted to CIGNA within twelve (12) months of the date charges are incurred. If the claim is not submitted on time, the claim will be denied unless it is shown that written proof of loss was given as soon as was reasonably possible.

Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

Claim Forms: If you are enrolled in CIGNA Tier I, II or III, you are generally not required to file a claim form in order to be reimbursed for service provided by in-network medical providers or for hospital benefits because most claims are submitted directly to CIGNA by the medical provider or the hospital. For out-of-network claims and participants in the Fund's CIGNA Medicare Eligible Retirees Program, a claim form must be submitted. Claim forms are available from the Fund Office (stop in or call: in New York City: (212) 247-5225, or, outside New York City, (800) WP-IATSE (974-2873)). Attach any other itemized hospital bills or doctor's statements that describe the services rendered. Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If a claim form has to be returned to you to obtain additional information, delays in processing will result.

Where to send your Post-Service claim: Your claim will be considered to have been filed as soon as it is received by CIGNA at the following address:

Connecticut General Life Insurance Company (CIGNA)
CIGNA HealthCare Service Center
P.O. Box 188036
Chattanooga, TN 37422-8036
(888) 336-8258

Processing of Claims (Applicable to All Post-Service Claims for Benefits)

Timing of Notification

For notification of a Pre-Service, Urgent Care and Concurrent Care claim determination, see the discussion above.

For all Post-Service claims, ordinarily, you will be notified of the decision on your claim within thirty (30) days from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to an additional fifteen (15) days if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the organization expects to render a decision. For benefits administered by CIGNA, this notice will include the date a determination can be expected, which will be no more than forty-five (45) days after receipt of the request.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have forty-five (45) days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either forty-five (45) days or until the date you respond to the request (whichever is earlier). The organization responsible for deciding your claim then has fifteen (15) days to make a decision on a Post-Service claim and notify you of the determination. For CIGNA claims, the determination period will be suspended on the date CIGNA sends a notice of missing information and resume on the date you or your representative responds to the notice.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- For Urgent Care claims, the notice will describe the expedited review process applicable to Urgent Care claims. For Urgent Care claims, the required determination may be provided orally and followed with written notification.

For Pre-Service, Urgent Care or Concurrent Care claims, you will receive notice of the determination even when the claim is approved.

APPEAL PROCEDURE

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review.

The Fund maintains a mandatory appeal process, which varies depending on the type of claim you are appealing, the nature of the benefit involved and the organization to which you are making your appeal. The Fund also offers a voluntary level of review for CIGNA benefits after you have exhausted all other mandatory appeals as described in this section.

Overview

In general, for all adverse benefit determinations (i.e., claim denials), you have the right to review documents relevant to your claim. A document, record or other information is relevant if: (1) it was relied upon by the organization responsible for deciding your claim in making the decision; (2) it was submitted, considered or generated (regardless of whether it was relied upon); (3) it demonstrates compliance with the organization's administrative processes for ensuring consistent decision making; or (4) it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your appeal will be reviewed by a person at a higher level of management than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Review Process and Timing of Notification

Important Note on Eligibility Issues: If your request for review relates to your eligibility to receive benefits through the Fund, your request for review must be made in writing to the Fund Office within sixty (60) days after you receive notice of denial. For such eligibility appeals, the Board of Trustees will make a determination on your appeal at its next regularly scheduled meeting following the Fund's receipt of your request for review of your claim. However, if your request for review is received by the Fund within thirty (30) days preceding the date of such meeting, then the benefit determination on appeal will be made by the Board of Trustees by no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances require a further extension of time for processing, your benefit determination will be rendered not later than the third meeting of the Board of Trustees. If such an extension is required, the Fund Manager shall, not later than the commencement of the extension, provide you with written notice of the extension, describing the special circumstances and the date as of which your benefit determination will be made. You will receive a notice of decision on review within five (5) days of the Board of Trustees making the benefit determination.

Appeal Procedures for CIGNA Claims

Overview: Any Pre-Service, Urgent Care, Concurrent Care or Post-Service appeal related to medical, hospital or prescription drug claims should be made in writing within three hundred sixty five (365) days of the receipt of the denial to CIGNA at the address below. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. You may submit your appeal in writing to:

CIGNA HealthCare
PACES Unit
P.O. Box 37963
Charlotte, North Carolina 28237-7963

Appeals may also be made orally by calling CIGNA at (800) 251-0669 Monday through Friday during regular business hours and asking to be connected to the National Appeal Unit. If you call after hours, follow the recorded instructions if you wish to leave a message.

CIGNA will acknowledge your appeal in writing within five (5) working days after it has received the appeal. This acknowledgement will include the name, address, and telephone number of the person designated to respond to your appeal and will indicate what information, if any, must be provided.

CIGNA maintains a mandatory two-level appeal procedure for medical, hospital and prescription drug claims. You may also choose to submit a voluntary third-level appeal to the Board of Trustees (discussed below).

In addition, if your appeal for medical or hospital benefits is denied based on absence of medical necessity or the service requested is an experimental or investigational treatment, you may request an External Appeal as described below.

Level One Appeals: You or your authorized representative, with your acknowledgement and consent, must submit your Level One appeal as described above. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For Level One Pre-Service and appropriate Concurrent Care appeals, CIGNA will respond in writing with a decision within fifteen (15) days. If more information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review. You are not obligated to grant CIGNA an extension or to provide the requested information.

For Level One Post-Service and appropriate Concurrent Care appeals, CIGNA will respond in writing with a decision within thirty (30) days after it receives the appeal.

Level Two Appeals: If you are dissatisfied with your Level One appeal decision, you may request a second review. A Level Two appeal must be made in writing to CIGNA within three hundred sixty five (365) days of receipt of the Level One Appeal denial.

For Level Two appeals, CIGNA will acknowledge in writing that they have received your request and schedule a Committee review.

Most requests for a second review will be conducted by CIGNA's Administrative Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving medical necessity or clinical appropriateness, the Committee will consult with at least one physician reviewer in the same or similar specialty as the care under consideration as determined by CIGNA's physician reviewer. You may present your situation to the Committee in person or by conference call.

For Level Two Pre-Service and appropriate Concurrent Care appeals, CIGNA will respond in writing with a decision within fifteen (15) days after it receives the appeal.

For Level Two Post-Service and appropriate Concurrent Care appeals, CIGNA will respond in writing with a decision within thirty (30) days after it receives the appeal.

Expedited Appeals for Urgent Care or Concurrent Care Claims: For either a Level One or Level Two appeal, you may request that the review process be expedited for Urgent Care or Concurrent Care claims denials if the time frames under this process would: (1) increase risk to your health, (2) seriously jeopardize your life, health or ability to regain maximum function, or (3) in the opinion of your physician would cause you severe pain which cannot be managed without the requested services.

You may also request that the appeal of a Level Two review determination be expedited if your appeal involves: (1) a Pre-Service claim in which the health care provider believes an immediate appeal is

warranted; or (2) a Concurrent Care claim of: (a) an authorization of an admission or continuing inpatient stay; or (b) continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider.

CIGNA's physician reviewer, in consultation with the treating physician, will decide if an expedited review is necessary. When a review involving an Urgent Care or Concurrent Care claim is expedited, CIGNA will respond orally with a decision within forty-eight (48) hours for the Level One appeal and within two (2) working days for a Level Two appeal, after receiving all the necessary information, but no later than seventy-two (72) hours after receiving the appeal. A written notice of the decision will be transmitted within seventy-two (72) hours after receiving the appeal. In addition, when a review involving an Urgent Care or Concurrent Care is expedited, CIGNA will provide reasonable access to its clinical peer reviewer within one (1) working day after receiving the appeal.

Voluntary Level Three Appeal: Should an adverse benefit determination be made upon review of your claim by CIGNA, you will have an opportunity to choose a voluntary Level Three appeal before the Board of Trustees. This Level Three appeal is **completely voluntary**; it is **not** required by the Plan and is only available if you (or your representative) request it.

With regard to claims procedures pertaining to the voluntary appeal:

- The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the voluntary level of appeal;
- Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously in this chapter. Please note that the statute of limitations starts to run when the decision on the last mandatory appeal is issued (Level One or Level Two, as applicable) and is only tolled from the date the Fund Office receives your written request for a voluntary Level Three Appeal until the decision on the Level Three Appeal is issued;
- Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation, specific information regarding the process for selecting a decision-maker and any circumstances that may affect the impartiality of the decision-maker.

The Plan will not impose fees or costs on you (or your representative), should you or your authorized representative choose to invoke the voluntary appeals process. Your decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan.

If you have any questions, please call the Fund Office. To request a Level Three appeal, requests should be made to the Board of Trustees within one hundred eighty (180) days of notification of determination of the Level Two Appeal at:

Board of Trustees
Welfare Fund of Local No. One, I.A.T.S.E.
320 West 46th Street, 6th Floor
New York, NY 10036
(212) 247-5225

For Urgent Care and applicable Concurrent Care voluntary appeals, the Board of Trustees, or its designee, will review your appeal and notify you within seventy-two (72) hours after receipt of your request for review.

For required Pre-Service and applicable Concurrent Care coverage determinations, the Board of Trustees' or its designee's review will be completed and you will be notified of its decision within fifteen (15) days after receipt of your request for review.

For Post-Service and applicable Concurrent Care appeals, the Board of Trustees' review will be completed no later than the date of the meeting that immediately follows your request for review. However, if your request for review is filed within thirty (30) days before such meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of your request for review. If special circumstances require a further extension of time, you will be notified of the extension and the date as of which the benefit determination will be made. You will receive a notice of decision on review within five (5) days of the Board of Trustees making the benefit determination.

Notice of Decision on Review (Applicable to All Appeals for All Benefits)

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement describing available voluntary appeal procedures and your right to obtain information about these procedures;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation.

In addition, for every appeal in which coverage is denied on the basis that the service is not medically necessary or is an experimental or investigational treatment, the notice of adverse determination must include: (1) a clear statement describing the basis and clinical rationale for the denial; (2) a clear statement that the notice constitutes an adverse determination; (3) the applicable contact person and his or her telephone number; (4) the insured's coverage type; (5) the name and full address of the review agent, if any; (6) the review agent's contact person and his or her telephone number; (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service; (8) a statement that you may be eligible for an external appeal and the time frames for requesting an appeal; and (9) a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the adverse determination of the Level One appeal, regardless of whether Level Two appeal is requested, and that by choosing to request a Level Two internal appeal, the time may expire for you to request an external appeal.

External Appeal (Applicable to Certain CIGNA Benefits)

Your Right to an External Appeal

The External Appeal Program is a voluntary program. You have a right to bring an external appeal for a denial of coverage under certain circumstances. Specifically, if CIGNA has denied coverage for medical or hospital benefits on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals. An external appeal may be brought after either a Level One or Level Two appeal. However, you must file for an external appeal within forty-five (45) days of receiving a notice denying your Level One appeal.

If CIGNA has denied coverage on the basis that the service is not medically necessary or that treatment is experimental or investigational, you may appeal to an external appeal agent if you satisfy the following criteria:

- The service, procedure or treatment is a covered expense under this Plan; and
- You have received an adverse determination through the Plan's internal appeal process (in which CIGNA has upheld the denial) or you and CIGNA agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A life-threatening condition or disease is one which according to the current diagnosis of your attending physician has a high probability of death. A disabling condition or disease is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen (18), a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by CIGNA or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered expenses (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life threatening or disabling condition or disease.

Submitting an External Appeal

You may request an External Appeal application from the New York State Insurance Department at (800) 400-8882 or its website (www.ins.state.ny.us) or the New York State Department of Health at its website (www.health.state.us) or CIGNA's Member Services department at the toll-free number on your Benefit ID card.

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance.

If you have received an adverse determination on your Level One appeal, which upholds the denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have forty-five (45) days from receipt of such notice to file a written request for an external appeal. If you and CIGNA have agreed in writing to waive any internal appeal, you have forty-five (45) days from receipt of such waiver to file a written request for an external appeal. CIGNA will provide an external appeal application with the adverse determination issued through the Level One appeal process or its written waiver of an internal appeal. It will be presumed you received the notification of denial of coverage within eight (8) days of the date on the notification.

Your physician may file an external appeal by completing and submitting the "New York State External Appeal Application For Health Care Providers To Request An External Appeal Of A Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release the medical records.

You will lose your right to an external appeal if you do not file an application or an external appeal within forty-five (45) days from your receipt of the Level One appeal adverse determination, regardless of whether you choose to pursue a Level Two appeal with CIGNA. CIGNA does not have the authority to grant an extension of this deadline. If you seek a Level Two appeal, you may not have time to request an external appeal.

Submit the completed application to New York State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent. You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which CIGNA or the HMO based its denial, the external appeal agent will share this information with CIGNA in order for it to exercise its right to reconsider its decision. If CIGNA chooses to exercise this right, it will have three (3) working days to amend or confirm its decision. In the case of an expedited appeal as described in the following section, CIGNA does not have the right to reconsider its decision.

You will be charged a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. This fee will be waived if CIGNA determines that paying the fee would pose a hardship to you. If the denial of coverage is overturned by the external appeal, the fee shall be refunded to you.

Decisions on External Appeals

In general, the external appeal agent must make a decision within thirty (30) days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or CIGNA or the HMO. If the external appeal agent requests additional information, it will have five (5) additional working days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) working days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request expedited external appeal. In that case, the external appeal agent must make a decision within three (3) days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and CIGNA or the HMO by telephone or facsimile of the decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, you will be provided with coverage subject to the other terms and conditions of this document. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. CIGNA will not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing research, or costs which would not be covered under this certificate for nonexperimental or noninvestigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and CIGNA. The external appeal agent's decision is admissible in any court proceeding.

Complaints/Appeals to the State of New York

At any time in the appeals process you may contact the New York State Department of Health (for medically related issues) or the New York State Department of Insurance (for billing/contract related issues) at the following address and telephone number to register your complaint:

New York State Department of Health
Metropolitan Regional Area Office
5 Penn Plaza, 2nd Floor
New York, NY 10001
(212) 268-6306 or (800) 206-8125

or

New Rochelle Area Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10810
(914) 654-7199 or (800) 206-8125

or

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
(800) 342-3736

Limitation on When a Lawsuit May Be Started

If you have submitted a claim or filed for an appeal/review and have not received a decision on the claim/appeal or notice that an extension will be necessary to reach a decision, within the time frames outlined above, then that claim/appeal will be treated as having been denied as of the due date for notification of a denial for purposes of the Claim Procedure and Appeal Procedure described above.

You may not start a lawsuit to obtain benefits until after you have requested all *mandatory* levels of appeal/review, and a final decision has been reached on your appeals/reviews. No lawsuit may be started more than three years after the end of the year in which medical services were provided or more than one year after determination of the final appeal/review, whichever is later. Any legal or equitable action for benefits under the Plan must be brought in the United States District Court for the Southern District of New York.

This SMM is intended to provide you with an easy-to-understand description of certain changes and/or clarifications to the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.