

Laborers' National Health & Welfare Fund

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SUMMARY OF MATERIAL MODIFICATIONS

TO: All Eligible Participants and Dependents of the Laborers' National Health & Welfare Fund

The Board of Trustees of the Laborer's National Health & Welfare Fund hereby announces the following changes to the Laborers' National Health & Welfare Fund Summary Plan Descriptions ("SPD"). These changes are effective January 1, 2003 and are made to comply with the new Department of Labor claims and appeals procedure rules.

REVISED PRECERTIFICATION, CLAIMS AND APPEALS PROCEDURES

UTILIZATION REVIEW

Utilization Review is a program designed to help insure that all Covered Individuals receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - Hospitalizations
 - Skilled Nursing Facility
 - Hospice Care
- (b) Retrospective Review of the Medical Necessity of the Medical and/or Surgical services provided on an emergency basis or otherwise not precertified;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the Physician;
- (d) Certification of services and planning for discharge from a Health Care Facility or completion of medical treatment; and
- (e) Review and audits of the bills for the listed services.

The purpose of the Utilization Review Program is to determine what is payable by the Plan. *This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or any other Health Care Practitioner or Provider.*

A. What Pre-certification Is

Hospital Pre-Admission Certification (“Precertification”) requires you to have your proposed Hospital or other Health Care Facility stay reviewed by ULLICARE’s professional staff *prior to* any admission, except in a Medical Emergency. (See the definition of Medical Emergency in the Definitions chapter of this document) You, your Authorized Representative, or your Health Care Provider may initiate the Pre-certification process by calling ULLICARE at (800) 848-9200 between the hours of 8:00 a.m. and 6:00 p.m. (EST) Monday through Friday. You may designate an Authorized Representative to act on your behalf with respect to the Precertification process by completing the Representative Authorization Form located at the back of this booklet and faxing it to ULLICARE. However, in the event of a Claim for Urgent Care, a Health Care Practitioner with knowledge of your medical condition will be permitted to act as your Authorized Representative, without regard to whether a completed Representative Authorization Form is on file with ULLICARE.

Based upon the information provided by you and your Physician, ULLICARE will determine: (1) whether the Hospital or other Health Care Facility admission is Medically Necessary; (2) if the treatment might be provided on an outpatient basis or in some other setting; (3) the approved length of confinement; (4) the appropriateness of the Hospital or other Health Care Facility; and (5) the appropriateness of the course of treatment. In order to make these determinations, ULLICARE may require a second surgical opinion and/or additional pre-admission testing. If ULLICARE approves the admission, it will assign an initial number of days and notify you, your Physician and the Hospital or other Health Care Facility. When the initially approved days are up, ULLICARE’s professional staff will contact your Physician to learn if you will be discharged or if your Physician believes that an extension of your admission is required. If ULLICARE agrees, additional days of inpatient care will be approved.

If ULLICARE does not approve the admission (or the extension of the initially approved stay), you have a right to request the Board of Trustees to review ULLICARE’s decision.

B. Pre-certification Procedures

1. Pre-certification of Urgent Care

In the event that the Pre-certification involves a Claim for Urgent Care (that is not a Medical Emergency), ULLICARE will notify you of the Plan’s benefit determination (whether approval or denial) as soon as possible, but in no event later than 72 hours after ULLICARE receives your request for Precertification.

However, if you fail to provide sufficient information to process the Precertification, ULLICARE will notify you as soon as possible (but not later than 24 hours after ULLICARE receives your request for Precertification) of the specific information it needs to complete the Precertification, and you will be given at least 48 hours to provide such information. In such case, ULLICARE will notify you of the Plan’s benefit determination as soon as possible, but not later than 48 hours after ULLICARE receives the specified information or after the period you are given to provide the information ends, whichever is earlier.

In the event that you or your Authorized Representative or your Health Care Provider requests an extension of your approved length of confinement or a change in the approved course of treatment that involves a Claim for Urgent Care, ULLICARE must notify you of the Plan’s benefit determination (whether approval or denial) as soon as possible, but in no event later than 24 hours after ULLICARE receives the request provided that the request is made at least 24 hours prior to the expiration of your approved admission or course of treatment.

2. *Pre-certification of Non-Urgent Care*

In the event that the Pre-certification does *not* involve a Claim for Urgent Care, ULLICARE must notify you of the Plan's benefit determination (whether approval or denial) within a reasonable period of time, but in no event later than 15 days after ULLICARE receives your request for Precertification. ULLICARE may extend this period for up to an additional 15 days if an extension is necessary due to matters beyond the control of the Plan and ULLICARE notifies you of the extension prior to the end of the initial 15-day period. This notice will describe the reasons for the extension and the date by which ULLICARE expects to make its decision.

However, if the extension of the 15-day period is necessary because you failed to provide sufficient information to process the Precertification, the extension notice will describe the specific information needed to complete the Precertification, and you will be given at least 45 days to provide such information. In such case, ULLICARE will notify you of the Plan's benefit determination within a reasonable period of time after you provide the required information, but not later than 15 days after ULLICARE receives such information.

Any reduction or termination of an approved length of confinement or course of treatment prior to the end of such confinement or course of treatment (except by plan amendment or termination) will be treated as the Plan's adverse benefit determination, which means that you will receive notice from ULLICARE of the denial and you will have the opportunity to appeal the decision before the benefit is reduced or terminated.

3. *Review of Pre-certification Denial*

If ULLICARE does not approve your Pre-certification request, ULLICARE will notify you in writing of the denial in accordance with the time frames set forth above. The following information will be provided to you in the notice:

- specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial was based;
- description of any additional material or information necessary to complete the Precertification and an explanation of why such material or information is necessary;
- description of the Plan's procedures for a full and fair review, including the applicable time limits in which you may file an appeal and a statement of your right to bring a civil action under Section 502(a) of ERISA;
- if the denial is based on an internal rule, guideline, protocol, or other similar criteria, either the internal rule, guideline, protocol, or other similar criteria or a statement that such information will be provided to you without charge upon your request;
- if the denial is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request; and
- if the denial involves a Claim for Urgent Care, a description of the expedited review process.

In the case of a denial of a Claim for Urgent Care, you can request the Board of Trustees to review ULLICARE's decision either orally or in writing, and all necessary information may be transmitted by telephone, facsimile or other similar expedited method. If the decision on review involves a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is

Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees will consult with a Health Care Practitioner with appropriate training and experience in the field of medicine involved in the medical judgment. The Board of Trustees will notify you of its decision on review as soon as possible but not later than 72 hours after receipt of your request for review. To the extent that you have been provided the medical services for which you requested Precertification, your request for review will be treated as a review of a post-service claim (see “B. Request Review of Denial of Claim” under REVIEW PROCEDURE IF YOUR CLAIM IS DENIED).

In the case of a denial of Pre-certification for non-urgent care, you can request the Board of Trustees to review ULLICARE’s decision in writing. If the decision on review involves a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Committee will consult with a Health Care Practitioner with appropriate training and experience in the field of medicine involved in the medical judgment. The Board of Trustees will notify you of its decision on review not later than 30 days after receipt of your request for review. To the extent that you have been provided the medical services for which you requested Pre-certification, your request for review will be treated as a review of a post-service claim (see “B. Request Review of Denial of Claim” under REVIEW PROCEDURE IF YOUR CLAIM IS DENIED).

If, upon review, the Board of Trustees upholds the denial of Pre-certification, the Board of Trustees will notify you in writing of the denial in accordance with the time frames set forth above. The following information will be provided to you in the notice of decision on appeal:

- specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial was based;
- statement that you are entitled to receive, upon request and free of charge reasonable access to, and copies of all Relevant Documents;
- the following statement: “You and your Plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your U.S. Department of Labor office and your State insurance regulatory agency.”
- statement of your right to bring a civil action under Section 502(a) of ERISA;
- if the denial is based on an internal rule, guideline, protocol, or other similar criteria, either the internal rule, guideline, protocol, or other similar criteria or a statement that such information will be provided to you without charge upon your request;
- if the denial is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request; and
- statement that the identity of any health experts consulted (without regard to whether the advice was relied on in making the benefit determination) will be provided to you without charge upon your request.

C. In the Case of A Medical Emergency

If you or your Physician could not contact ULLICARE prior to the admission because of a Medical Emergency, you or your Physician should contact ULLICARE as soon as possible, but no less than 72 hours after the admission.

D. Failure to Follow Pre-certification Procedures

If you fail to follow the procedures for Pre-certification and ULLICARE receives a communication describing you, your specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, then ULLICARE will notify you and explain the proper procedures to follow to obtain Precertification. Such notification will be provided to you orally (unless you request written notification) as soon as possible but not later than 5 days (24 hours in the case of a Claim for Urgent Care) after ULLICARE becomes aware of your failure to follow Precertification procedures.

If Pre-certification is not obtained prior to your admission in a Hospital or other Health Care Facility or within 72 hours after such admission in a Medical Emergency, a \$50 penalty will be charged to you if ULLICARE determines that the admission would have been approved as Medically Necessary. However, if ULLICARE determines the admission (or part of the inpatient stay) would not have been approved as Medically Necessary, the expenses will not be Eligible Medical Expenses and, thus, would not be paid by the Fund.

E. CASE MANAGEMENT

Case Management is used to coordinate, monitor and manage complex and costly cases, usually involving serious Illnesses or Injuries. Serious Illnesses or Injuries include: chronic illnesses, acute catastrophic injury, infectious diseases, burns, terminal illnesses, neonatal complications, transplants, and AIDS and AIDS-related cases.

A Case Manager will be assigned and will contact you and your family to discuss your medical care needs. Your Case Manager can help you and your Physician arrange and coordinate needed services after your discharge. They will also review your case to determine how your health needs can best be met within your existing Plan Benefits. If special benefits are required, the Case Manager may recommend alternate levels of care (such as a Skilled Nursing Facility or a Qualified Hospice Program) and identify additional medical resources that may be available to you. These are recommendations only and the patient, the attending Physician and the patient's family must all agree.

HOW TO CLAIM BENEFITS UNDER THE PLAN

A. Payment of Plan Benefits in General

1. All Plan Benefits are considered for payment upon receipt of a Claim Form at the Fund Office. You and your Authorized Representative may file a Claim Form with the Fund Office. You may designate an Authorized Representative to act on your behalf to file a Claim Form by completing the Representative Authorization Form at the back of this booklet and faxing or mailing it to the Fund Office. You may also obtain the Representative Authorization Form from the Fund Office by writing or calling the telephone number below.
2. Once the Claim Form is received by the Fund Office, it will be reviewed by the Claims Administrator to verify your or your Dependent's eligibility, and to determine whether the expenses are covered by the Plan and how much is payable by the Fund. If further information is needed by the Fund, you, your Authorized Representative, or your Health Care Provider may be contacted.

3. Generally, Benefits payable on account of expenses for a Hospital will be paid directly to the institution providing the services. Likewise, Benefits payable on account of expenses for Surgery will be paid directly to the surgeon or anesthesiologist providing the services. However, if, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee that you and/or your Eligible Dependent paid some or all of those charges, Benefits will be paid to you up to the amount covered by your Plan. When Deductibles, Coinsurance or Co-payments apply, you are responsible for paying your share of the charges directly to the Health Care Provider.
4. The Fund does not permit the assignment of Plan Benefits to any persons or institutions other than Hospitals or other Health Care Facilities, surgeons and anesthesiologists, so all other Plan Benefits will be paid directly to you (or to a designated beneficiary in the case of Life and AD&D benefits).

REVIEW PROCEDURES IF YOUR CLAIM IS DENIED

A. Written Notice of Denial of Claim

The Fund will notify you in writing if payment of your claim is denied in whole or in part. You will receive such notice of your post-service claim within a reasonable period of time, but not later than 30 days after the Fund receives your claim. The Fund may extend this period for up to an additional 15 days, provided that the extension is necessary due to matters beyond the control of the Plan and the Fund notifies you of the extension prior to the end of the initial 30-day period. This notice will describe the reasons for the extension and the date by which the Fund expects to make its decision.

However, if the extension is necessary because you failed to provide sufficient information to decide the claim, the extension notice will describe the specific information needed to decide the claim, and you will be given at least 45 days to provide such information. In such case, the Fund will notify you of the Plan's benefit determination as soon as possible after you provide the required information, but not later than 15 days after the Fund receives such information.

If your claim is denied in whole or in part, the following information will be provided to you in the notice of denial of claim:

- specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial was based;
- description of any additional material or information necessary to process the claim and an explanation of why such material or information is necessary;
- description of the Plan's procedures for a full and fair review, including the applicable time limits in which you may file an appeal and a statement of your right to bring a civil action under Section 502(a) of ERISA;
- if the denial is based on an internal rule, guideline, protocol, or other similar criteria, either the internal rule, guideline, protocol, or other similar criteria or a statement that such information will be provided to you without charge upon your request; and
- if the denial is based on Medical Necessity or Experimental or Investigational treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request.

B. Request for Review of Denial of Claim

If your claim is denied, or if you disagree with the amount paid on a claim, you may ask for a review by the Board of Trustees. Your request for a review of a denied claim must be made in writing to the Board of Trustees, sent to the Fund Office, within 180 days after you receive written notice of the denial. Your written appeal should state clearly the reason(s) for your appeal. You must include any documents or other proof that you have to support your appeal with your letter.

The appeals process works as follows:

1. Your appeal will be reviewed by the Board of Trustees.
2. The decision on any review of your claim will be given to you in writing. If, upon review, the Board of Trustees upholds the denial, the following information will be provided to you in the notice of decision on appeal:
 - specific reason(s) for the denial;
 - reference to the specific plan provisions on which the denial was based;
 - statement that you are entitled to receive, upon request and free of charge reasonable access to, and copies of all Relevant Documents;
 - the following statement: “You and your plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your U.S. Dept. of Labor office and your State insurance regulatory agency.”
 - statement of your right to bring a civil action under Section 502(a) of ERISA;
 - if the denial is based on an internal rule, guideline, protocol, or other similar criteria, either the internal rule, guideline, protocol, or other similar criteria or a statement that such information will be provided to you without charge upon your request;
 - if the denial is based on medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the denial applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided to you without charge upon your request; and
 - statement that the identity of any health experts consulted (without regard to whether the advice was relied on in making the determination) will be provided to you without charge upon your request.
3. You may review any Relevant Documents held by the Fund applicable to your claim free of charge upon your request.
4. Ordinarily, the Board of Trustees will review your appeal at the next regularly scheduled quarterly meeting immediately following receipt of your appeal. If you file your appeal within 30 days of the next quarterly meeting, the Board of Trustees will review your appeal by no later than the date of the second quarterly meeting following receipt of your appeal.
5. The Board of Trustees, in reviewing your appeal, will not afford deference to the initial adverse benefit determination and will take into account all comments, documents, records and other information submitted by the claimant and/or obtained by the Claims Administrator. In addition, if the decision on review involves a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Board of Trustees will consult with a Health Care Practitioner with appropriate training and experience in the field of medicine involved in the medical judgment.

6. You will be notified of the decision on appeal within 5 days after the decision is made.

NEW DEFINITIONS

Authorized Representative

An individual whom you authorize to act on your behalf with respect to the Precertification process, claims filing process or claims appeal process. Such authorization will be effective once you complete the Representative Authorization Form at the back of this booklet and return it to ULLICARE if your Authorized Representative will be acting on your behalf with respect to the Precertification process. Or, return it to the Fund Office if your Authorized Representative will be acting on your behalf with respect to the claims filing and/or appeals processes. However, in the event of a Claim for Urgent Care, a Health Care Practitioner with knowledge of your medical condition will be permitted to act as your Authorized Representative, without regard to whether a completed Representative Authorization Form is on file.

Claim for Urgent Care

Any claim for medical care or treatment with respect to which application of the time periods for making a Precertification decision involving non-urgent care –

- 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 requested care or treatment.

Any claim that a physician with knowledge of your medical condition determines is a Claim for Urgent Care will be treated by the Plan as a Claim for Urgent Care. In the absence of a determination by your physician, the determination of whether a claim involves urgent care is to be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Relevant Documents

Documents, records and other information (i) relied upon in making the benefit determination; (ii) submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative processes and safeguards required to ensure that benefit claim determinations are made in accordance with governing plan documents and that the plan provisions have been applied consistently with respect to similarly situated claimants; or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosed condition, without regard to whether such advice was relied upon in making the benefit determination.