

**4<sup>th</sup> DISTRICT IBEW HEALTH FUND**

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**IMPORTANT NOTICE ABOUT CHANGES TO THE PLAN**

June 1, 2011

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This Notice explains important changes that are being made to the 4<sup>th</sup> District IBEW Health Plan. The changes to the Plan described in this Notice are effective for claims incurred, based on date of service, on and after June 1, 2011. You are urged to carefully review this Notice and address any questions to the Benefit Office or the Board of Trustees. This Notice should be kept with your records of Plan activities.

**Changes Required under the Patient Protection and Affordable Care Act**

Benefit changes adopted by the Trustees effective June 1, 2011 result in the loss of "grandfathered" status as detailed in the Patient Protection and Affordable Care Act. As a result, the following additional change is required.

The plan will implement a **standard internal and external review** process as summarized below:

For *internal appeal reviews*, the following standards apply:

- An adverse benefit determination includes rescissions of coverage, pre- and post-service claim determinations, exclusions, limitations, and eligibility determinations;
- Benefit determinations relating to urgent care claims generally must be made to claimants within 24 hours of receipt of the claim;
- Claimants must be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim;
- Notices must be provided in a culturally and linguistically appropriate manner;
- All claims and appeals must be handled in a way that is designed to ensure impartiality;
- Notices to claimants must provide additional content such as identifying information on the claim, denial codes, description of available appeals processes and contact information for health insurance consumer assistance.

For *external appeal reviews*, the following standards apply:

- Request For External Review: Claimants will be allowed to file a request for an external review, provided that the request is filed within four months of the date of the notice of adverse benefit determination (denial).