AMENDMENT

TO

YMCA OF THE FOX CITIES
EMPLOYEE HEALTH AND WELFARE PLAN

Effective July 1, 2019, the **YMCA OF THE FOX CITIES EMPLOYEE HEALTH AND WELFARE PLAN** (the "Plan") is hereby amended in the following manner:

ARTICLE II – INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

In section 2.02 General Plan Information:

Remove the following language entirely:

The Affordable Care Act

This group health plan believes this plan is a "Grandfathered Health Plan" under the Affordable Care Act (ACA). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

YMCA of the Fox Cities
218 East Lawrence Street
Appleton, WI 5491

Participants may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers. This website (in the Regulations and Guidance/Grandfathered Health Plans section) has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Plan Status:
Grandfathered is to change to Non-Grandfathered

ARTICLE III – DEFINITIONS

The following changes shall be made:

1. Adverse Benefit Determination – add the following language to this definition:

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

2. Add the following definition:

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Health Care Research, Centers for Medicare and Medicaid Services (CMS), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by National Institutes of Health (NIH) guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless Out-of-Network benefits are otherwise provided under the Plan.

3. Add the following definition:

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

4. Delete and replace the definition of "Preventive Care" with the following:
"Preventive Care" shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

ARTICLE VII – SUMMARY OF BENEFITS

In section 7.06 Summary of Medical Benefits:

Replace the following language entirely:

	Network	Non-Network	Limits
Deductible Individual Family Unit (Embedded Deductible)	 $1,000 $2,000	 $2,000 $4,000	
Payment Level (unless otherwise stated)	80%	60%	
Out-of-Pocket Maximum* Individual Family Unit	 $2,000 $4,000	 $4,000 $8,000	
*Out-of-Pocket Maximum, per Calendar Year, includes: • Deductible, Coinsurance and Copayments (medical and prescription drug). The following charges do not apply toward the Out-of-Pocket Maximum: • Cost containment penalties, ineligible charges, and amounts over the Usual & Customary.			

Allergy Services • Office Visit • Injections • Serum	$70 copay, then 80% after Deductible	Deductible, then 60%	

Outpatient Emergency Services	$150 copay, then 80% after Deductible	Network Benefits Apply	Copay is waived if Participant is admitted.

Physician Services – **Primary Care Visit** **Specialist Care Visit** Includes office visit services, lab and x-ray if provided the same day by the same provider or clinic. Does not include surgical procedures, magnetic resonance imaging (MRI), and computerized axial tomography (CAT scan).	 $35 copay, then 100% $70 copay, then 100%	 Deductible, then 60% Deductible, then 60%	

Preventive Care - Well Child Care • Routine Physical Exam • Lab and X-rays • Routine Immunizations	100% No Cost Share	Deductible, then 60%	

Preventive Care - Well Adult Care • Routine Exams • Mammograms – must be over the age of 40 unless Medically Necessary • Pap Smears • Prostate Exam – must be over age 40 unless Medically Necessary • Routine Immunizations	100% No Cost Share 100% No Cost Share	Deductible, then 60% Deductible, then 60%	Routine Exam and Mammograms are limited to one per calendar year. Routine Exam includes all related x-ray and lab tests, immunizations and other diagnostic tests (i.e. colonoscopies)

Psychiatric Expenses • Residential Treatment • Inpatient Treatment • Partial Day Program • Outpatient Office Visit	Deductible, then 80% $70 copay, then 100%	Deductible, then 60% Deductible, then 60%	Inpatient Requires Pre-Certification.
Substance Abuse Benefits • Residential Treatment • Inpatient Treatment • Partial Day Program • Outpatient Office Visit	Deductible, then 80% $70 copay, then 100%	Deductible, then 60% Deductible, then 60%	Inpatient Requires Pre-Certification.

Add the following language entirely with the following:

Urgent Care	$50 copay, then 100%	Deductible, then 60%	

ARTICLE VIII – MEDICAL BENEFITS

In section 8.01 Medical Benefits:

The following should be replaced entirely with the following:

11. **Contraceptives.** The charges for all Food and Drug Administration (FDA) approved contraceptives Drugs and methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *Oral contraceptives are covered under the Prescription Drug Benefits section.*

30. **Preventive Care.** Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

    Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/coverage/preventive-care-benefits/ for more details.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

a. Well-woman visits.
b. Gestational diabetes screening.
c. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
d. Sexually transmitted infection counseling.
e. Human Immunodeficiency Virus (HIV) screening and counseling.
f. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
g. Breastfeeding support, supplies and counseling.
h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/coverage/preventive-care-benefits/.

35. **Sterilization for Men.** Charges for male sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA).

In section 8.01 Medical Benefits:

The following should be added to this section:

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of Cancer or a life-threatening Disease or condition, as defined under ACA, provided:

a. The clinical trial is approved by:

i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
ii. The National Institute of Health.
iii. The U.S. Food and Drug Administration.
iv. The U.S. Department of Defense.
v. The U.S. Department of Veterans Affairs.
vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

In section 8.02 Exclusions:

The following should be replaced entirely with the following:

44. **Nutritional Supplements.** For nutritional supplements, except as specified under Preventive Care.

The following should be added to this section:

Routine Patient Costs for Participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
d. A cost associated with managing an Approved Clinical Trial.
e. The cost of a health care service that is specifically excluded by the Plan.
f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

ARTICLE X – PRESCRIPTION DRUG BENEFITS

Delete the following sentence:

The Copayment amount is not counted toward any out of pocket maximums under the Plan.

Replace the above sentence with the following:

The Copayment amount does count toward the out of pocket maximums listed in the Summary of Benefits section.

Delete Sections 10.01, 10.02 and 10.03 and replace with the following:

10.01 Covered Expenses

The following are covered under the Plan:

1. Contraceptives. The charges for all Food and Drug Administration (FDA) approved contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines.

10.02 Limitations

The benefits set forth in this Article will be limited to:

1. Dosages.
   a. With respect to the Pharmacy Option, any one prescription is limited to a 30 day supply.
   b. With respect to the Mail Order Option, any one prescription is limited to a 90 day supply.
   c. With respect to the Specialty Drug Option, any one prescription is limited to a 30 day supply.
2. Refills.
   a. Refills only up to the number of times specified by a Physician.
   b. Refills up to one year from the date of order by a Physician.

10.03 Exclusions

For information on medications not covered by the Plan, please call the Prescription Benefit Manager for assistance.

ARTICLE XII – CLAIM PRCEDURES; PAYMENT OF CLAIMS

Sections 12.02C through 12.03F shall be deleted entirely and replaced with the following:

12.02C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Participant 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 Participant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.

10. In a claim involving urgent care, a description of the Plan's expedited review process.

12.03 Appeal of Adverse Benefit Determinations

12.03A Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, 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 any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.
9. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

12.03B Requirements for First Level Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

Prairie States Enterprises, Inc.
P.O. Box 23
615 Pennsylvania Ave

Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

For Post-service Claims. To file any appeal in writing, the Participant's appeal must be addressed as follows:

Prairie States Enterprises, Inc.
P.O. Box 23
615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

It shall be the responsibility of the Participant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Participant.
2. The Employee/Participant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

12.03C Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. 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.
2. 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.
3. 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.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. 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.

12.03D Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request.
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge upon request.
10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

12.03E Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

12.03F Decision on Review

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

12.03J External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or

issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the final regulations.
    d. The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

For more information, Participants may contact the Plan Administrator / Employer.

All other sections of the Plan remain unchanged.

APPROVED AND ACCEPTED

By: Celeeon A Breeden III
Signature

Title: President / CEO

Date: 7/16/19