THE TRUSTEES OF THE STEVENS INSTITUTE OF TECHNOLOGY HEALTH AND WELFARE BENEFIT PLAN

SUMMARY MATERIAL MODIFICATION

EFFECTIVE: January 1, 2012

External Review for Medical Claims

If you receive a final internal adverse benefit determination for a medical claim, you may have the right to have an external review of this decision. This means that your claim will be reviewed by health care professionals who have no association with either the insurance carrier or claims administrator who initially reviewed your claims. This is sometimes referred to as a review by an independent review organization, or IRO. Reviews may be provided for claim decisions that involve making a medical judgment as to the medical necessity or experimental and investigational exclusions, including but not limited to appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. You must submit an **Application for an Independent Health Care Appeal** to the New Jersey Department of Banking and Insurance, Office of Managed Care, P.O. Box 329, Trenton, NJ 08625-0329. The application and additional information regarding the Independent Health Care Appeals Program is available at the following website:

http://www.nj.gov/dobi/division_insurance/managedcare/ihcap.htm

The following is a summary of information that applies to external reviews of adverse benefit determinations. As noted in this summary, you will receive more detailed information if your denied medical claim is eligible for an external review.

1. The Plan's appeal process provides for external review of adverse benefit determinations (and final internal adverse benefit determinations) that involve making a medical judgment as to the medical necessity or experimental and investigational exclusions, including but not limited to appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.
2. At the time of the final internal adverse benefit determination, you will be provided with a written notice of your rights to external review that includes more detailed information on the external review process.
3. Unless you meet the following criteria, you will be required to exhaust the **internal** appeal process before you may submit a request for an external review. This requirement may be waived if:
   a) the insurance company or the plan's claims administrator notifies you that it is waiving the exhaustion requirement;
   b) the insurance company or claims administrator is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process (except those failures that are considered *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant); or
   c) you request both an expedited[1] **internal** appeal and an expedited **external** review at the same time as noted below.

[1] In cases where an expedited review is needed, notice of the decision of the claim must be provided no later than 72 hours after the request is received for either an expedited internal and/or external review. Additionally for external reviews, the IRO must provide written confirmation of the decision within 48 hours of the decision.

4. An expedited **internal** review request can be made in situations where an adverse benefit determination involves a medical condition for which the standard timeframe for the completion of the internal appeal process would seriously jeopardize the life or health of the claimant or would jeopardize your ability to regain maximum function.
5. An expedited **external** review request can be made in situations where an adverse benefit determination involves a medical condition for which the standard timeframe for the completion of the internal appeal process would seriously jeopardize the life or health of the claimant or would jeopardize your 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 yet been discharged from the facility.
6. You must be given up to four months following the date that you receive the adverse benefit determination or final internal adverse benefit determination to submit a request for external review of the medical claim.
7. Preliminary Review – Within five business days of receiving the request for external review, the insurance company or claims administrator must determine the following:
   a) if the claimant was covered under the Plan when the claim in question was incurred;
   b) if the adverse benefit determination is related to the claimant's failure to meet the Plan's eligibility requirements;
   c) if the claimant exhausted the internal appeals process if required by the Plan; and
   d) if the claimant provide all the information and forms required to process the external review.

   Within one business day after the completion of the preliminary review, the Plan must notify the claimant whether or not they are eligible for an external review. If it is determined that they are not eligible for an external review, the notice will include the reasons why the claim is ineligible and how to contact the Employee Benefits Security Administration (EBSA) at 866-444-EBSA (3272) for further assistance with your claim review. However, if the initial request was incomplete, you will be informed as to what information or materials are needed to complete the request. You will have up to the later of the end of the four-month filing period or within 48 hours of receiving notice of an incomplete request.

8. Your claim will be assigned to an independent review organization (IRO) to perform the external review. The IRO will timely notify you of its acceptance of your external review. The notice will also include a statement that you have ten business days, unless otherwise indicated, to submit any additional information that the IRO must consider when conducting the external review. The IRO has one business day to forward the additional information to the applicable insurance carrier or claims administrator.
9. Within five business days after the assignment of the IRO, the Plan will provide the IRO with the documents and other information used to make the adverse benefit determination. If the documents are not submitted timely, the IRO may terminate the external review process and reverse the adverse benefit determination or final internal adverse benefit determination.
10. The IRO must make a final external review decision within 45 days and notify the claimant within one day of such decision.
11. The IRO decision is generally binding on the claimant, as well as the plan or issuer (except to the extent that other remedies are available under State or Federal law).