NOTICE OF SUMMARY OF MATERIAL MODIFICATIONS TO TSRI HEALTH AND WELFARE PLANS
Effective January 1, 2013

The Employee Retirement Income Security Act (ERISA) requires that TSRI notify employees each time a material change is made to the health and welfare plan.

The changes described in this document affect health benefits and should be kept with your benefit materials for future reference. Please refer to the Health and Welfare Summary Plan Description for more information regarding the benefits listed below. These changes were communicated during the 2012 Open Enrollment period, or provide further clarification of existing language in the Summary Plan Description.

Comprehensive PPO Plan
The following changes are made to the Comprehensive PPO Plan:

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>In-Network: $200</td>
<td>In-Network: $400</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $400</td>
<td>Out-of-Network: $800</td>
</tr>
<tr>
<td>Family Maximum Deductible</td>
<td>In-Network: $600</td>
<td>In-Network: $1,200</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: $1,200</td>
<td>Out-of-Network: $2,400</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>In-Network: 90%</td>
<td>In-Network: 80%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70%</td>
<td>Out-of-Network: 60%</td>
</tr>
<tr>
<td>Well Baby Care</td>
<td>In-Network: 90%</td>
<td>In-Network: 100%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Not Covered</td>
<td>Deductible Does Not Apply</td>
</tr>
<tr>
<td>Cancer Screenings</td>
<td>In-Network: 90%</td>
<td>In-Network: 100%</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: 70%</td>
<td>Out-of-Network: 60%</td>
</tr>
<tr>
<td></td>
<td>Deductible Applies to All Services</td>
<td>Deductible Applies Only to Out-of-Network Services</td>
</tr>
<tr>
<td>Other Preventive/Routine Exams</td>
<td>In-Network: 90%</td>
<td>In-Network: 100%</td>
</tr>
<tr>
<td></td>
<td>Deductible Applies</td>
<td>Deductible Does Not Apply</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network: Not Covered</td>
<td>Out-of-Network: Not Covered</td>
</tr>
</tbody>
</table>

Catastrophic Medical Plan
The following changes are made to the Catastrophic Medical Plan:

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Baby Care</td>
<td>80% of UCR</td>
<td>100% of UCR</td>
</tr>
<tr>
<td></td>
<td>Deductible Applies</td>
<td>Deductible Does Not Apply</td>
</tr>
<tr>
<td></td>
<td>Inpatient Nursery Charges Only</td>
<td>All Eligible Well-Baby Care</td>
</tr>
<tr>
<td>Cancer Screenings</td>
<td>80% of UCR</td>
<td>100% of UCR</td>
</tr>
<tr>
<td></td>
<td>Deductible Applies</td>
<td>Deductible Does Not Apply</td>
</tr>
<tr>
<td>Other Preventive/Routine Exams</td>
<td>Not Covered</td>
<td>100% of UCR</td>
</tr>
<tr>
<td></td>
<td>Deductible Does Not Apply</td>
<td>Deductible Does Not Apply</td>
</tr>
</tbody>
</table>

Women’s Preventive Health Services (Comprehensive, Graduate Student and Catastrophic Medical Plans)
The following services are covered by the medical plans:

- Well-woman exams – as many as necessary to obtain specified preventive services
- Pre-natal exams, including:
o Routine prenatal obstetrical office visits/low risk, uncomplicated pregnancies
o All lab services explicitly required in HHS rules
o Tobacco cessation counseling specific to pregnant women

- Screening for gestational diabetes for all pregnant women (24-28 weeks)
- Human papillomavirus (HPV) DNA testing for all women age 30 and older every 3 years
- Counseling for sexually transmitted infections for all sexually active women
- Counseling, screening for human immune-deficiency (HIV) virus for all sexually active women
- Counseling for a payment of sterilizations
- Breastfeeding support, supplies and counseling
  o Part of pre/post-natal counseling
  o Coverage for rental of breast-feeding equipment

Erroneous Procedures (Comprehensive, Graduate Student and Catastrophic Medical Plans)
Surgeries or invasive procedures performed in error by a physician or other health care professional are not covered by the TSRI medical plans. Such procedures and all related services to those procedures will be denied reimbursement when one of the following procedures is performed erroneously:

- A different procedure than scheduled
- The correct procedure but on the wrong body part
- The correct procedure but on the wrong patient

Providers are expected to waive all costs associated with the wrong surgical or other invasive procedure and should report such services as described below. Participating providers may not bill or collect payment from TSRI benefit plan members for any amounts not paid due to the application of this reimbursement policy.

Consistent with CMS billing requirements, TSRI requires the reporting of these erroneous procedures in the manner described below:

Hospital Inpatient Claims: Hospitals are required to submit a no-pay claim (Type of Bill 110) to report all charges associated with the erroneous surgery. If there are also non-related services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims – one claim with services or procedures unrelated to the erroneous surgery and the other claim with the erroneous services or procedures as a no-pay claim.

The non-covered Type of Bill 110 must have one of the following ICD-9-CM diagnosis codes reported in diagnosis position 2-9 on the hospital claim to identify the type of erroneous surgery performed. These codes shall not be reported in the External Cause of Injury E-code) field.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

Hospital Outpatient, Ambulatory Surgery Center (ASC), and Professional/1500 Claims:
Outpatient, ASCs and physicians or other health care professionals must report the applicable HCPCS modifier(s) with the associated charges on all lines related to the surgical error:

- PA – Surgery Wrong Body Part
- PB – Surgery Wrong Patient
- PC – Wrong Surgery on Patient

Prescription Drug Copays (Comprehensive, Graduate Student and Catastrophic Medical Plan Enrollees)
Retail Pharmacies – per 30 day supply
$10 copay for generic drugs
$35 copay for brand name preferred drugs (previously $25)
$60 copay for non-preferred drugs (previously $50)

Mail Order – per 90 day supply
$20 copay for generic drugs
$70 copay for brand name preferred drugs (previously $50)
$120 copay for non-preferred drugs (previously $100)

A new requirement called DAW2 applies when a generic is available but the pharmacy dispenses the brand per the member’s request. In that instance, the plan member should pay the generic copay plus the difference in cost between the brand and the generic. If a physician writes “dispense as written” or “do not substitute” on the prescription, the applicable brand copay should apply in that instance.

Women’s contraceptives are covered at 100% without copays or deductibles applied, in compliance with The Patient Protection and Affordable Care Act. No pre-authorization is required for contraceptives.

**Plan Maximum (Health Care Spending Account Plan)**
The Patient Protection and Affordable Care Act and the Health Care Reconciliation Act of 2010 reduced the maximum contribution to a health care spending account plan. The maximum amount you may contribute is $2,500 per calendar year. Previously, there was a $5,000 maximum per calendar year.

**Grandfather Status**
TSRI believes the California HMO, Florida HMO, Comprehensive PPO, Graduate Student PPO and Catastrophic PPO Plans are no longer “Grandfathered Health Plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act).

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 (858) 784-8487 or at benefits@scripps.edu. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The following section replaces the Payment, Denial, and Review of Claims section of the Comprehensive, Graduate Student, and Catastrophic Medical Plans:
- **HW SPD 2010 CA FLEX (pgs. 53-54)**
- **HW SPD 2010 CA Res Assoc (pgs. 49-50)**
- **HW SPD 2010 CA TSRI Grad (pgs. 46-47)**
- **HW SPD 2010 FL Flex (pgs. 53-54)**
- **HW SPD 2010 FL Res Assoc (pgs. 49-50)**
- **HW SPD 2010 FL TSRI Grad (pgs. 44-45)**

**Payment, Denial, & Review of Claims (Comprehensive, Graduate Student and Catastrophic Medical Plans)**
The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim, which was not processed under the Utilization Review Program, cannot be processed due to incomplete information, the Claims Administrator will either deny the claim or send a Written explanation prior to the expiration of the 30 calendar days. If the Claims Administrator does not deny the claim and requests additional information to complete the review, the Claimant is then allowed up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, Benefits under the group Plan may be processed and paid within a few days after the Claims Administrator receives completed proof of loss. If a claim cannot be paid, the Claims Administrator will promptly explain why.
**Standard Appeal Review and Voluntary Appeal Review**

A standard appeal must be requested in writing and may either be mailed or faxed to the Claims Administrator. It must be requested within 180 calendar days of the receipt of an adverse benefit determination or rescission of coverage determination.

During the one hundred eighty (180) day period, you may:

- Submit written comments, documents, records, and other information relating to the claim for benefits;
- Present evidence and testimony; and
- Request and receive, free of charge, reasonable access to, and copies of, all relevant records.

To complete the standard appeal process, it may be necessary for the Claims Administrator to request a statement from the attending doctor or other ordering provider and request all or part of the medical records. A peer clinical reviewer who did not make the original determination, is not a subordinate of the peer clinical reviewer who made the original determination and who is in the same or similar specialty as the attending doctor or other ordering provider will conduct the review. No deference will be given to the prior adverse determination. The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The claims administrator will notify you of the plan's benefit determination on appeal in writing within a reasonable period, but not later than 60 days after receipt by the plan of the claimant’s request for review of an adverse benefit determination. The first level of appeal review must be completed before filing a civil action or pursuing any other legal remedies.

If the adverse benefit determination or rescission of coverage determination is affirmed on the appeal review, you, the patient, attending doctor or other ordering provider can request a voluntary appeal. The appeal must be requested in writing. You, the patient, attending physician or other ordering provider may submit written comments, documents, records, and other information relating to the request for appeal. The claims administrator will make a determination within 60 calendar days of request for a voluntary appeal. A peer clinical reviewer who did not make the original determination or the first appeal, is not a subordinate of the peer clinical reviewer who made the original determination or first appeal and who is in the same or similar specialty as the attending doctor or other ordering provider will conduct the review. No deference will be given to the prior adverse determination. The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. However, if the appeal cannot be processed due to incomplete information, the claims administrator will send a written explanation of the additional information that is required or an authorization for your or the patient’s signature so information can be obtained from the attending doctor or other ordering provider. This information must be sent to the claims administrator within 45 calendar days of the date of the written request for the information. Failure to comply with the request for additional information could result in declination of the appeal. A decision will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

Election of a second appeal is voluntary and does not negate your right or the patient’s right to seek external review, if eligible, or bring a civil action following notification of the decision rendered during the standard appeal, nor does it have any effect on your rights or the patient’s rights to any other benefit under the group plan. The voluntary appeal process is offered in an effort that the claim may be resolved in good faith without legal intervention. At any time during the second appeal process, you or the patient may file a civil action or pursue any other legal remedies. Any statute of limitations defense is tolled during the period of the voluntary appeal. 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 local U.S. Department of Labor office and your State insurance regulatory agency.
Expedited Appeals Involving Urgent Care Claims

If the adverse benefit determination involves an Urgent Care Claim you may submit a request, either orally or in writing, for an expedited appeal. If you request an expedited appeal of Urgent Care Claim, all necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

Timing of Notice of Benefit Determination on Appeal

Urgent Care Claims – In the case of an Urgent Care Claim, the Claims Administrator will notify you of the Plan’s benefit determination on appeal as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan’s receipt of your request for review of an adverse benefit determination.

Pre-Service Claims – In the case of a Non-Urgent Care Claim that is a Pre-Service Claim, the Claims Administrator will notify you of the Plan’s benefit determination on appeal within a reasonable period, but not later than thirty (30) days after receipt by the Plan of the Claimant’s request for review of an adverse benefit determination.

Post-Service Claims – In the case of a Non-Urgent Care Claim that is a Post-Service Claim, the Claims Administrator will notify you of the Plan’s benefit determination on appeal within a reasonable period, but not later than sixty (60) days after receipt by the Plan of the Claimant’s request for review of an adverse benefit determination.

External Review

You are entitled to seek review of certain claim denials by an independent external review organization. If you disagree with the Claims Administrator’s determination on internal appeal, you can seek review within four months of the decision. Your claim is eligible for external review if either:

- The Claims Administrator does not strictly adhere to all claim determination and appeal requirements under federal law (other than minor violations); or
- You have exhausted the standard levels of appeal and your appeal relates to (i) medical judgment, or (ii) a rescission, which is a retroactive cancellation or discontinuance of coverage.

Claims based on legal or contractual disputes and issues regarding eligibility are not eligible for external review.

If your internal appeal is denied and your claim is eligible for external review, you will be notified in writing, and you will be informed of the steps necessary to request an external review.

If you decide to seek external review, an independent external review organization (an “IRO”) will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The ultimate decision of the IRO is binding on you, the Claims Administrator, and the Plan.

Preliminary Review

After you request an external review, the Claims Administrator must make a preliminary assessment of your claim within five business days, confirming:

- You were covered under the Plan at the time the service was requested or provided.
- The determination relates to medical judgment or a rescission of coverage.
You have exhausted the internal appeals process (unless the Claims Administrator failed to strictly adhere to the appeal requirements, as discussed above); and

You have provided all paperwork necessary to complete the external review.

The Claims Administrator must notify you in writing within one business day of completing the preliminary assessment. If your request is complete but not eligible for external review, the Claims Administrator’s notice will provide (i) the reasons your request is ineligible, and (ii) contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If your request is not complete, the notice will describe the missing information or materials. The Claims Administrator will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.

**Referral to IRO**

Once your request is complete and determined to be eligible for external review, the Claims Administrator will assign an accredited IRO and provide the IRO with the internal file and other materials considered during the internal appeals process. The IRO will timely notify you in writing to (i) confirm your request’s eligibility and acceptance for external review, and (ii) provide you an opportunity to submit in writing, within ten business days following the date of receipt, additional information that the IRO should consider when conducting the external review. The IRO will forward any additional information you provide to the Claims Administrator, so that the Claims Administrator may consider whether to approve your claim based on the new information.

The IRO will review any information or documents you provide within the ten-day window. In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. The IRO will also consider, where appropriate:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider;
- The terms of your Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan (unless the terms are inconsistent with applicable law);
- Appropriate practice guidelines, including applicable evidence-based standards, and any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer.

The IRO will provide written notice of the final external review decision to you, the Claims Administrator, and the Plan, within 45 days of the date it receives the claim.

If the IRO overturns the Plan's denial of your claim, the Plan will immediately provide coverage or payment for your claim.

**Expedited External Review**

You may immediately request an expedited external review at the time you receive:

- An initial internal claim denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;
• A final internal appeal denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or

• A final internal appeal denial involving an admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of your request, the Claims Administrator will determine whether the request is eligible for expedited external review. The Claims Administrator will immediately send you a notice of its eligibility determination.

Upon a determination that a request is eligible for expedited external review following preliminary review, the Claims Administrator will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Claims Administrator, and the Plan with a written notification of its decision within 48 hours.

**Maintenance of Appeals Records**

The IRO will maintain records of all claims and notices associated with the external review process for six years. The records will be available for examination by you, the Plan, or any state or federal oversight agency upon request, except where disclosure would violate state or federal privacy laws.