PLAN UPDATE
Updates to Your Summary Plan Description Special Notice Winter 2002

This Plan Update contains important information about your rights under the Motion Picture Industry Pension and Health Plans and under ERISA. Please keep it with your Summary Plan Description for future reference.

NEW CLAIMS AND APPEALS PROCEDURES FOR HEALTH PLAN PARTICIPANTS

Summary

The Motion Picture Industry Health Plan is proud to be instituting new procedures to ensure prompt processing of your claims and appeals, relating to claims received on or after January 1, 2003, where the initial benefit determination is in any way adverse. In coordination with the U.S. Department of Labor, these new measures will also apply to your dental and vision plans, any HMO option you may have selected, and your PacifiCare Behavioral Health benefits.

Preauthorizations As you know, all covered Plan benefits are allowed based on, among other things, medical necessity of the service or procedure. In an effort to eliminate any possible delay or prevent any of our Participants from the medical services that they require:

The Plan itself will no longer require you to obtain preauthorization for any covered benefits (from MPIHP only – other contracted networks have their own pre-authorization guidelines, example: Blue Cross, Kaiser, etc.).

Some services may not meet the requirement of medical necessity. ***To avoid any unnecessary out of pocket expense or payments, it may be in your best interest to request preauthorization of those services to verify coverage by the Plan*** (e.g. see page 51 of the Active Health Summary Plan Description and page 40 of the Retiree Health Summary Plan Description). This will be your option starting January 1, 2003. If you are concerned about the coverage of a proposed service or procedure, please have your physician send a letter of medical necessity to Medical Review, MPIHP, P.O. Box 1999 Studio City, CA 91614-0999.

A claim will not be denied on the basis that it was not preauthorized, but it may not be covered due to other benefit limitations or exclusions.

Medical Claims The Plan is committed to generally processing all your complete medical claims within 30 days of receipt. In fact, our new system automatically handles many claims within just a few days of submission. If additional information is required in order to finalize the processing, you and/or your physician (provider) will be contacted in writing and an extension will go into effect. At that time we will stop our "30-day clock." Once your response to the request is received or time has elapsed for your response to be received, whichever is earlier, an additional 15 days will be available to finalize the processing of the claim.

Inquiries and clarifications about a claim or claims decision should be directed to the Participant Services Department of the Plan, at 310 or 818.769.0007, extension 244.

Requests for Appeal If you feel that your claim or request has not been processed correctly, you have 180 days following the receipt of your explanation of benefits to make a formal request for review by the Directors' ***Benefits/Appeals Committee***.

Please submit in writing your reasons in clear and concise terms and include any other pertinent medical documentation that will help us to understand the situation. Your request must be addressed to Benefits/Appeals Committee, MPIHP, P.O. Box 1999, Studio City, CA 91614-0999. The Directors schedule meetings once a month to review files. The Committee's decision shall be final and binding on all parties, including the Participant and any person claiming under the Participant. You will be notified of their decision in writing. See the details in the attached notice.

All of the Plan's contracted Health Networks are also committed to expediting your claims and requests in a timely manner. See the details in the attached notice.

Please take this time to review the specifics outlined on the attached pages. In addition, keep this notice with your July 2002 Health Summary Plan Description (SPD) for future reference if the time arises that you are concerned about the processing of claims or considering a request for review.

The attached Notice supercedes the claims review procedures contained in the current SPD for Participant or dependent initiated claims and appeals. The next printed SPD will incorporate these changes.

MOTION PICTURE INDUSTRY PENSION & HEALTH PLANS

Telephone Access to MPIPHP

In California
818 or 310.769.0007

Outside So. California
888.369.2007

Participant Services
Extension 244
7 a.m. to 5 p.m.
Claims Inquiries
Health Benefits

Pension Department
Extension 627
8 a.m. to 5 p.m.
Death Benefit
Pension History Print-outs
Refund of Employee Contributions
Retirement
Retirement Benefit Calculation Statements

Eligibility Department
Extension 263
8 a.m. to 5 p.m.
Address Changes
Adding Dependents
Plan Enrollments

Medical Review
Extension 286
8 a.m. to 5 p.m.
Case Management
Health Claims
Home Intravenous Therapy
Independent Medical Examination
Nursing Care
Preauthorization
Second Surgical Opinion

New Claims and Appeals Procedures for Health Plan Participants, Effective January 1, 2003

In coordination with the U.S. Department of Labor's recently enacted regulations, the Motion Picture Industry Health Plan will be implementing new claims and appeals procedures for Participant or dependent initiated health service claims received on and after January 1, 2003, where the initial benefit determination is in any way adverse. These new procedures will also apply to your dental and vision plans, any HMO option you may have selected, your PacifiCare Behavioral Health Benefit ("PBH") and certain other items. While similar claims and appeals processing procedures have been previously made available to you, the new procedures should be even more helpful to you.

As you can see below, we have described separately the new time lines applicable to claims and appeals that you file (1) directly with the Plan ("MPIHP"), and (2) with the contract providers of the Plan such as HMO's, PBH, dental and vision plans, and Blue Cross (for hospital-related matters).

We have included a description of how each process will work, and what information will be made available to you. Because there are some changes from previous procedures, we recommend that you read this Notice carefully.

I. CLAIMS AND APPEALS YOU FILE DIRECTLY WITH MPIHP

- As in the past, you will continue to file benefit claims regarding your MPIHP/Blue Cross (Indemnity) Plan (other than hospitalization precertifications and claims) and any appeals of those claims determinations, directly with MPIHP.
- The Plan has previously required pre-authorization for a number of benefits available under this option. As of January 1, 2003, however, it will no longer require pre-authorization for such benefits, (other than non-emergency hospitalizations, which are processed separately by Blue Cross). **We still strongly recommend that you obtain pre-authorization guidance where it is currently required in your Summary Plan Description**, because we believe it is a benefit to you to do so. The Plan will not, however, deny a claim because you have not obtained such pre-authorization approval under this option. The Plan may, however, as in the past, deny a benefit, in whole or in part, based on other Plan guidelines or terms. ***Note:*** The elimination of the pre-authorization requirement does not extend to Blue Cross non-emergency hospitalization claims, or those pre-authorizations currently required by entities that the Plan has contracted with to provide benefit options. See discussion in Section II on page 3.
- Claims filed with the Plan should be addressed as follows:

Claims Department
Motion Picture Industry Health Plan
P.O. Box 1999
Studio City, California 91614-0999

A. New Time Limits For MPIHP To Process Your Claims

What is the general deadline for initial determination?	30 days from the Plan's receipt of the completed claim.*
Are there any extensions?	Yes: One 15 day extension, if the Plan determines it is necessary due to matters beyond the control of the Plan and informs the claimant of the extension within this time frame.**
What is the deadline if additional information is needed?	If an extension is necessary because the claimant failed to provide necessary information, the notice of extension must specify the information needed. Claimant must be given at least 45 days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 days.

* In the case of a claim where "disability" must be determined by the Plan (as opposed to a neutral third party such as the Social Security Administration or California State Disability Insurance), to determine qualification for a benefit, this number of days is 45.

** In the case of a claim where "disability" must be determined by the Plan (as opposed to a neutral third party such as the Social Security Administration or California State Disability Insurance), to determine qualification for a benefit, this number of days is 30, with the possibility of an additional 30-day extension.

Claims should be submitted within 90 days from the day the services were rendered for an illness or injury. Claims *must* be submitted within 15 months from the date of service or 15 months from the date the primary payor paid, in coordination of benefits situations. Failure to timely file may result in the denial of your claim.

B. Claim Questions and Appeals

If you have any questions about the processing of, or decision concerning, your claim, you should contact the Plan Office at 818 or 310.769.0007 ext. 244. If you wish to appeal the Plan's decision to the Plan's Benefits/Appeals Committee you must address your appeal to:

Benefits/Appeals Committee
Motion Picture Industry Health Plan
P. O. Box 1999
Studio City, CA 91614-0999

All such appeals must be in writing and state in clear and concise terms the reason for your disagreement with the decision. The failure to file such an appeal within the time frame specified below (180 days from your receipt of the initial adverse decision) shall constitute a waiver of the right to review of the decision, and such decision shall be final and binding. Such failure will not, however, prevent the applicant from establishing entitlement at a later date based on additional information and evidence, which was not available at the time the decision denying the claims, in whole or in part, was made.

New Time Limits For MPIHP Processing Your Appeals

How long does a participant have to appeal?	180 days following receipt of a notification of adverse benefit determination.
What is the appeal deadline by which the claimant must be notified of an appeals decision?	Appeals will be heard at the Benefits/Appeals Committee meeting that follows receipt of the appeal if it is received more that 30 days in advance of the meeting. If received less that 30 days before the meeting, the appeal may be heard at the second meeting after such receipt, however, if special circumstances exist, the Committee will inform the Participant of the need for a further extension, what those special circumstances are, and the date the appeal will be decided. In that instance the appeal will be decided, not later than the date of the third meeting following the appeals request. You will be provided notice of the appeals decision within five days of the decision.

If you are receiving previously approved ongoing treatment (e.g., kidney dialysis) for a specific period of time (or number of treatments), and the Plan intends to reduce or terminate such coverage before the end of that period, you must be provided notice of this change sufficiently in advance to allow an appeal and decision on the appeal. The new Department of Labor guidelines refer to such claims as a type of "concurrent care" claim.

The Plan pays only those benefits established by the Plan's Directors. The Benefits/Appeals Committee shall have the discretion and final authority to interpret and apply the Plan of Benefits, the Trust Agreement and any and all rules governing the Plan. The decision of the Benefits/Appeals Committee shall be final and binding upon all parties, including the Participants and any person claiming under the Participant, subject to a claimant's right to bring a civil action under Section 502(a) of ERISA. These provisions apply to and include any and every claim to benefits under the Plan and any claim or right asserted against the Plan, regardless of the basis asserted for the claim.

II. CLAIMS AND APPEALS YOU FILE WITH MPIHP CONTRACT PROVIDERS

As in the past, there are a number of other health care options made available to you through companies which the Plan contracts with, such as HMO's, PBH, Blue Cross (with respect to hospitalization-related matters) dental, vision, and others. Claims and appeals for health care services made available through these entities are ordinarily handled by the entities themselves, rather than MPIHP. For those entities, the time frame for claims review depends on what type of claim is being filed, and we describe for you on the following pages how those different types of claims are handled. You should remember that these guidelines are minimum guidelines for these contract providers and so you should also check with them, and your Summary Plan Description, to determine if even more beneficial terms are available.

As indicated above, time frames for the contract providers to process your health claims and any appeals depend on the type of claim filed. Such claims fall into the following categories:

- **Claims That Require Pre-Authorization**. Unlike the Plan, these entities will continue to require pre-authorization in a number of instances, as set forth in your SPD and separate materials you have received from them. This Notice does not alter those pre-authorization requirements. You should consult your Summary Plan Description and contract provider for more information regarding such pre-authorization matters. The new Department of Labor guidelines refer to claims where pre-authorization is required as "pre-service claims."
  - — Urgent Care Claims That Require Pre-Authorization are a type of claim that requires pre-authorization, but which also involves medical care needed quickly to avoid seriously jeopardizing the life or health of the patient or to treat severe pain which could not otherwise be adequately managed. The determination of whether these conditions are met can be made by either the patient's treating physician or a representative of the entity processing your claim. The new Department of Labor guidelines refer to this type of pre-authorization claims as "urgent care claims."
- **Claims Not Requiring Pre-Authorization**. This is the type of claim filed after the service has been provided, and where no pre-authorization is required. The new Department of Labor guidelines refer to these claims as "post-service claims."

A. New Time Limits For MPIHP Contract Providers To Process Your Claims

	Claims Not Requiring Pre-Authorization ("Post-Service Claims")	Claims Requiring Pre-Authorization ("Pre-Service Claims")	Urgent Care Claims Requiring Pre-Authorization ("Urgent Care Claims")
What is the general deadline for initial determination?	30 days from receipt of the claim.*	15 days from receipt of the claim.	72 hours from receipt of the claim. If, on an urgent care basis, claimant wishes to extend a treatment beyond the time for which it has been previously approved, the claim shall be decided within 24 hours if the claim is made at least 24 hours prior to the time at which it would have otherwise ended. (The new Department of Labor guidelines refer to this kind of claim as a type of "concurrent care" claim.)
Are there any extensions?	Yes: One 15-day extension, if the entity which processes the claim determines it is necessary due to matters beyond its control and informs the claimant of the extension within this time frame.**	Yes: One 15-day extension, if the entity which processes the claim determines it is necessary due to matters beyond its control and informs the claimant of the extension within this time frame.	No, but see below for extensions based on insufficient information.
What is the deadline if additional information is needed?	If an extension is necessary because the claimant failed to provide necessary information, the notice of extension must specify the information needed. Claimant must be given at least 45 days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 days.	If an extension is necessary because claimant failed to provide necessary information, the notice of extension must specify the information needed. Claimant must be given at least 45 days to respond. The running of time for the initial claims determination is stopped until the end of the prescribed response period or until information is received, whichever is earlier. At that point the decision will be made within 15 days.	Claimant must be notified of the need for additional information within 24 hours of receipt of the claim. Claimant must be given at least 48 hours to respond. The running of time is suspended for 48 hours or until the information is received, whichever is earlier.

* In the case of a claim where "disability" must be determined by MPIHP or an MPIHP contract provider (as opposed to a neutral third party such as Social Security or California State Disability), to determine qualification for a benefit, this number of days is 45.

** In the case of a claim where "disability" must be determined by MPIHP or an MPIHP contract provider (as opposed to a neutral third party such as Social Security or California State Disability), to determine qualification for a benefit, this number of days is 30, with the possibility of an additional 30-day extension.

B. Appeals Time Limits For MPIHP Contract Providers

	Claims Not Requiring Pre-Authorization ("Post-Service Claims")	Claims Requiring Pre-Authorization ("Pre-Service Claims")	Urgent Care Claims Requiring Pre-Authorization ("Urgent Care Claims")
How long does a participant have to appeal?	180 days following receipt of a notification of adverse benefit determination.	180 days following receipt of a notification of adverse benefit determination.	180 days following receipt of a notification of adverse benefit determination.
What is the appeal deadline by which claimant must be notified of appeals decision?	If one required level of appeal: 60 days from receipt of the appeal. If two required levels of appeal: 30 days from receipt of the appeal for each level.	If one required level of appeal: 30 days from receipt of the appeal. If two-required levels of appeal: 15 days from receipt of the appeal for each level.	72 hours from receipt of the appeal.*

* In conjunction with such an appeal, a claimant may submit information by any expeditious method including fax, phone or other electronic means, or orally.

If you are receiving previously approved ongoing treatment (e.g., kidney dialysis) for a specific period of time (or number of treatments), and the entity providing the benefit intends to reduce or terminate such coverage before the end of that period, you must be provided notice of this change sufficiently in advance to allow an appeal and decision on the appeal. The new Department of Labor guidelines refer to this as a type of "concurrent care" claim.

III. INFORMATION TO BE MADE AVAILABLE TO YOU IN CONNECTION WITH YOUR CLAIM

While much information regarding your claim was previously available to you, the new guidelines further clarify the information you are entitled to receive.

- **Initial Benefits Determinations**, which are in any manner adverse, will include the following:

1. The specific reason or reasons for any adverse determination.
2. Reference to the Summary Plan Description or related provisions on which the determination is based.
3. In the event that a rule on protocol was relied on, it will be identified and either set forth or stated that it will be provided, at no charge, upon request.
4. If the adverse decision is based on medical necessity, experimental treatment, or similar exclusion or limitation, a clinical or scientific explanation will be provided or it will be stated that such will be provided, at no charge, upon request.
5. A statement regarding the claimant's right to bring a civil action under Section 502(a) of ERISA.
6. A description of any alleged material or information that would be needed to perfect the claim, and why that material or information is needed.
7. A description of the claims appeals procedure.

- **Appeals Determination**. In appeals determinations, the following information shall be made available:

1. The same type of information provided in Nos. 1-5 above, with respect to Initial Benefit Determinations.
2. A statement that the claimant is entitled to receive, upon request, and at no charge, reasonable access to and copies of documents, records and other information related to the claim for benefits.

MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS

P.O. Box 1999, Studio City, California 91614-0999

Address Service Requested

50 YEARS OF INDUSTRY SERVICE *Check out our website at* www.mpiphp.org

IV. NATURE OF APPEALS PROCESS FOR YOUR CLAIM

The new guidelines mandate that the appeals process be an independent one in the sense that it shall take a fresh look at the relevant documents, and not just defer to the conclusion of the initial decision-maker. You the claimant shall have the right to submit any additional documents or information for the appeal, whether or not such information was submitted to the initial decision maker. In the event that the disposition of an appeal is based on medical necessity, experimental treatment, or similar exclusion or limit, the appeals process shall utilize a health care professional who has appropriate training and experience in that field of medicine, and who was (1) not consulted in connection with the initial adverse benefit determination being reviewed; and (2) not the subordinate of the decision-maker in the initial determination. These latter two requirements are new as is your right to obtain, upon request, the identity of any medical or vocational experts from whom advice was obtained in connection with an adverse benefit determination. You similarly have the right to obtain in connection with your appeal, at no charge and upon request, reasonable access to and copies of documents relevant to your appeal, as provided under ERISA guidelines.

You also, under the new guidelines, have the right to utilize another person to represent you during the claims and/or appeals process. If you wish to take advantage of this, you must notify the MPIHP Plan (or other entity if such other entity is processing your claim and/or appeal) and you may be required to fill out an appropriate form. The Plan or the contract provider offering the benefit reserves the right to verify that any such designation is authentic. In the case of an urgent care claim (requiring preauthorization) made to an MPIHP contract provider, a health care professional with knowledge of the Participant's medical condition may act as the authorized representative of the patient.

The time limits discussed in this Notice may be extended if both the clamant and the entity processing the claim agree to do so.

Please keep this information with your July 2002 Health Summary Plan Description for future reference. This Notice supercedes the claims review procedures contained in the current Summary Plan Description for Participant or dependent initiated claims and appeals. The next printed Summary Plan Description will incorporate these changes.