INTERNAL CLAIMS AND APPEALS PROCEDURES

This section describes the procedures followed by the Iron Workers District Council of Western New York and Vicinity Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for Medical/Hospital, Prescription Drug, Dental, Orthodontics, Optical, Hearing Aid, Employee Assistance Program (EAP), Life Insurance, Accidental Death and Dismemberment, Supplementary Disability, Wage Replacement Account Benefits (Supplemental Disability, Workers' Compensation, Unemployment and Vacation Benefits).

The Plan's internal claims and appeal procedures are designed to provide You with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to You and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate or is Experimental or Investigational).

General Information

Claims Administrators

Initial claims decisions are issued by the following companies/organizations:

Benefit Type and Claims Administrator	Types of Claims Processed
Medical/Hospital and Hearing Aid Benefits Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647 (800) 499-1275 www.excellusbcbs.com	• Pre-Service Claims; • Urgent Care Claims; • Concurrent Review; • Post-Service Claims.
Employee Assistance Program (EAP) Services Workforce Development Institute 96 South Swan Street Albany, NY 12210 (800) 252-4555 (800) 225-2527 www.theEAP.com	• EAP Service Claims

Benefit Type and Claims Administrator	Types of Claims Processed
Prescription Drug Benefits Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (800) 451-6245 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com	• Pre-Service Claims; • Urgent Care Claims; • Concurrent Review Claims; and • Post-Service Claims for prescriptions filled at Out-of-Network retail pharmacies.
Self-insured Health Benefits: Dental, Orthodontia, Optical, and Hearing Aid. **Self-insured Non-Heath Benefits: Accidental Death and Dismemberment, Supplemental Disability, and Wage Replacement Account** Iron Workers District Council of WNY Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623-2950 (800) 288-0782 (585) 424-3510	• Post-Service Claims • Accidental Death and Dismemberment Claims • Supplementary Disability Claims • Wage Replacement Account Claims
Life Insurance Benefits Prudential Life Insurance of America 80 Livingston Avenue Roseland, New Jersey 07068	• Life insurance Claims (You must obtain a life insurance claim form from the Fund Office or Prudential).
Wage Replacement Account Life and Accidental Death and Dismemberment Insurance Benefits The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233	• Life insurance Claims (You must obtain a life insurance claim form from the Fund Office or The Hartford).

Days Defined
For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

I. Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit (collectively, "denial"), including any denial based on (1) a determination of an individual's eligibility to participate in the Plan, (2) an application of utilization review, or (3) a determination that the item is Experimental, Investigational, or not Medically Necessary or appropriate;
- A rescission of coverage, whether or not there is an adverse effect on any particular health or disability benefit. An adverse benefit determination does not include rescissions of coverage with respect to life insurance and dismemberment insurance/death benefits.

All notices, to the extent required by applicable law, will be provided in a culturally and linguistically appropriate manner.

Definition of a Claim

A claim is a request for a Plan benefit made by You or Your covered Dependent (also referred to as "claimant") or Your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

II. Health Benefit Claims

Health benefit claims can be filed for Medical/Hospital, Prescription Drug, Dental, Optical, Orthodontics, Hearing Aid, and Employee Assistance Program (EAP) Benefits.

There are four categories of health claims as described:

- ***Pre-Service Claims*** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical/hospital services and prescription drugs.

  Please note that while a Pretreatment Review/Advance Claim Review is suggested for a proposed course of dental treatment that is estimated to be over $150, there is no penalty for failure to obtain this review. If no Pretreatment Review/Advance Claim Review is obtained prior to services being rendered, the claim will be treated as if an Advance Claim Review was obtained. These Reviews are not considered pre-service claims.

- ***Urgent Care Claims*** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims*** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Supplementary Disability Benefit Claims

A Supplemental Disability Claim is a request for benefits during a period of disability. Supplemental Disability Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

Life Insurance and Accidental Death and Dismemberment Insurance Claims

A request for Life Insurance and/or the Accidental Death Benefit may be completed by a designated Beneficiary following the death of a Participant. A claim for the Accidental Dismemberment Benefit may be completed by the Participant along with the proof of a bodily loss.

Wage Replacement Account Benefits (Supplemental Disability, Workers' Compensation, Unemployment and Vacation Benefits)

See the section entitled *Wage Replacement Account Benefits* for details on claims and appeals procedures for these benefits.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than You, Your eligible dependent(s), or an Authorized Representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, You may file a claim with the Plan;

- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, You may file a claim with the Plan.

If You submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify You about information which is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures. A claim may be filed by You, a covered Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be Your authorized representative.

Health Care Claims – (And determinations conditioned on a finding of disability by the Plan)

The Plan will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give You a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, You will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give You a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims**

Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided You are given written (or electronic, as applicable) notification before the expiration of the initial fifteen (15) day determination period.
If You improperly file a Pre-Service Claim, the Claims Administrator will notify You in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, You must re-file a claim to begin the Pre-Service Claim determination process.
If a claim cannot be processed due to insufficient information, the Claims Administrator will notify You in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, You will have 45 days following Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives Your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify You in writing (or electronically, as applicable).

- **Urgent Care Claims**

In the case of an Urgent Care Claim, if a health care professional with knowledge of Your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be Your authorized representative bypassing the need for completion of the Plan's written authorized representative form.
The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision by telephone to You and Your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.
If you improperly file an Urgent Care Claim, the Claims Administrator will notify You and Your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, You must re-file a claim to begin the Urgent Care Claim determination process.
If a claim cannot be processed due to insufficient information, the Claims Administrator will provide You and Your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, You will have not less than 48 hours following receipt of the notice to supply the additional information. If You do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to You and Your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for You to provide this information, whichever is earlier.

- **Concurrent Claims**

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow You to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim, will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved, You will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, You will be notified orally with written (or electronic, as appropriate) notice.

Post-Service Claims (Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided You are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify You in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, You will have 45 days after Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives Your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify You in writing (or electronically, as applicable).

Supplemental Disability Claims – Decision Timeframes

Claims for Supplemental Disability benefits will be decided no later than 45 days after receipt by the Fund Office. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided You are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date You are notified of the delay. The period for making a decision may be delayed an additional 30 days due to matters beyond the control of the Plan, provided You are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the decision should be rendered.

If a claim cannot be processed due to insufficient information, You will be notified in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, You will have 45 days after Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date Your written response to the request for information is received. The Plan then has 30 days to make a decision and notify You in writing (or electronically, as applicable).

Life Insurance and Accidental Death and Dismemberment Claims – Decision Timeframe

Generally, You will receive written (or electronic, as applicable) notice of a decision on Your initial claim within 90 days of receipt of Your claim by the Claims Administrator. If additional time or information is required to make a determination on Your claim, for reasons beyond the control of the Claims Administrator, You will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determination of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies Your initial claim, in whole or in part, You will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to You in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims will include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims, will include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review (for health benefit claims) processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, either the rule, etc., or a statement of such rule, guideline, protocol or similar criteria that was relied upon will be provided to You free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to Your medical circumstances; or a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to You free-of-charge upon request;
- For Urgent Care claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist You with the Plan's internal claims and appeal processes as well as with the external review process for health benefit claims.
- With respect to claims conditioned upon a finding of disability by the Plan, the notice will also include:

- a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating physician, or health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

- A statement that You are entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, You will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to You and Your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- ***Health Care Claims*** **(Applicable to Medical/Hospital, Prescription Drug, Dental, Optical, Hearing Aid and Employee Assistance Program (EAP) Benefits)**

If an initial health care claim is denied (in whole or in part) and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, You may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- ***Supplemental Disability Claims***

If an initial Supplemental Disability Claim is denied and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an internal appeal. You have 180 calendar days following Your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

- ***Life Insurance and Accidental Death and Dismemberment Claims***

Any appeal must be made in accordance with the terms of the applicable insurance policy. To request a copy of the policy, please contact the Fund Office. Generally, if an initial life insurance or accidental death and dismemberment Claim is denied and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an appeal. You have 60 calendar days following Your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period. To the extent there is a conflict between this SPD and the terms of the applicable insurance policy, the insurance policy controls.

Internal Appeals Process

III. Appeal Procedures

To file an internal appeal of a self-insured benefit, You must submit a written statement to the appropriate party as described below within **180 days** of the adverse benefit determination:

Appeals for Medical/Hospital Benefits

The Plan maintains a two-level Appeal Process for Medical/Hospital benefits, except it maintains a one-level Appeal Process for Urgent Care Medical/Hospital benefits. First level appeals for Medical/Hospital Benefits should be submitted to Excellus at the address found in the Quick Reference Chart.

Second Level appeals should be submitted to the Board of Trustees at the address found in the Quick Reference Chart.

Appeal requests involving Urgent Care Claims may be made orally by calling the telephone numbers provided in the Quick Reference Chart or the number found on Your ID card.

Appeals for Prescription Drug Benefits

The Plan maintains a one level Appeal Process for Prescription Drug benefits. Appeals for prescription drug benefits should be submitted to Express Scripts at the address found in the Quick Reference Chart.

Appeal requests involving Urgent Care Claims may be made orally by calling Excellus or ESI at the telephone number listed on the Quick Reference Chart or the one found on Your ID card.

Appeals for all other self-insured benefits (Supplemental Disability, Dental, Orthodontia, Optical, and Hearing Aid Benefits)

The Plan maintains a one-level Appeals Process for these Benefit Claims. Appeals should be submitted to the Board of Trustees at the address found in the Quick Reference Chart.

Your request for an internal appeal must include the specific reasons why You believe the initial claim denial was improper. You may submit any document that You feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will:

- Provide You with the opportunity to submit to the Plan written comments, documents, records, and other information relating to Your initial claim for benefits;

- Provide You with the opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to Your initial claim for benefits;

- Provide You with a full and fair review that takes into account all comments, documents, records, and other information submitted by You, without regard to whether such information was submitted or considered in the initial claim determination;

- Provide You with a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, or Medically Necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- ***Health Care Claims***

    - ***Pre-Service Claims for Prescription Drug Benefits.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days from the date Your written request for an appeal is received by ESI.

    - ***Pre-Service Claims for Medical/Hospital Benefits.*** Under the Plan's two-level appeals process, Excellus will notify You of its first-level determination no later than 15 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, You may request a second level of review by the Board of Trustees. You will have 180 days from the date You received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 15 days after the Plan receives Your request for a second-level appeal review.

- ***Urgent Care Claims for Medical/Hospital and Prescription Drug Benefits.*** You will be notified of the determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than 72 hours after the appropriate Claim Administrator's receipt of Your (oral or written) request for appeal. A claim involving Urgent Care is any claim with respect to which the application of the time periods for making non-urgent care could seriously jeopardize Your ability to regain maximum function or, in the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan will defer to determination of Your attending provider regarding whether the claim involves urgent care.

- ***Concurrent Claims for Medical/Hospital and Prescription Drug Benefits.*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the appropriate Claims Administrator. You will be notified of the determination of Your internal appeal as soon as possible before the benefit is reduced or treatment is terminated.

- ***Post-Service Claims for Prescription Drugs.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days from the date Your written request for an appeal is received by ESI. No extension of the Plan's internal appeal review timeframe is permitted.

- ***Post-Service Claims for Medical/Hospital Benefit Claims.*** Under the Plan's two-level appeals process, Excellus will notify You of its first-level determination no later than 30 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, You may request a second level of review by the Board of Trustees. You will have 180 days from the date You received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 30 days after the Plan receives Your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

- ***Post-Service Claims for all other self-insured benefits (Dental, Optical, Employee Assistance Program (EAP) and Supplemental Disability Benefits.)*** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of Your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of Your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered no later than the third meeting following the Plan's receipt of Your written request for review. If such an extension is necessary, the Plan will provide You with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify You in writing (or electronically, as applicable) of the benefit determination no later than five calendar days after the benefit determination is made.

- ***Life Insurance and Accidental Death and Dismemberment Benefit Claims***

A written (or electronic, as applicable) notice regarding a determination of Your appeal will be sent to You in accordance with the applicable insurance policy; generally, within 60 days from the date Your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination Upon Appeal

Any notice of denial of Your appeal will include the following, to the extent applicable to your claim:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount);
- The specific reasons for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provisions on which the denial is based;
- A statement describing the availability, upon request, of the diagnosis code (if applicable) and the treatment code (if applicable) and their corresponding meanings;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- A statement that You have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding a denied internal appeal of a health benefit claim;
- If the denial was based on an internal rule, guideline, protocol, or similar criterion, either the rule, etc., or a statement will be provided that such rule, guideline, protocol, standard or criteria will be provided free of charge, upon request;
- If the denial of a health benefit or disability claim was based on either the medical judgment (Medical Necessity, Experimental, or Investigational), or a statement that the Plan will provide an explanation, free of charge, upon request, of the scientific or clinical judgment for the denial, applying the Plan's terms to Your medical circumstances;
- If applicable, a statement describing voluntary appeal procedures for prescription drug claims; and
- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist You with internal claims and appeals and external review processes.

- A statement that the claimant 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 claimant's claim for benefits;

- With respect to a claim conditioned on a finding of disability by the Plan, the notice will also include:

    - The basis for disagreeing with, or not following (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

    - Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

    - Any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

Note, to the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within ten days.

Voluntary Appeal for ESI Prescription Drug Claims

The Plan offers an additional voluntary appeal level for Prescription Drug claims administered by Express Scripts after the standard appeals process is completed. Therefore, if You are dissatisfied with the outcome of Your standard appeal, You may file a voluntary second-level appeal with the Board of Trustees within 90 calendar days from the date on the notice of the letter denying Your first appeal.

You should also submit written comments, documents, medical records, and other information relating to the claim for benefits. In administering the voluntary appeal, the Plan will obtain a written report summarizing the facts underlying the claim and prior denials from ESI.

Decisions on voluntary appeals will be made at the next regularly-scheduled meeting of the Board of Trustees following receipt of Your request for review. However, if Your request for review is received within 30 days of the next regularly-scheduled meeting, Your request for review will be considered at the second regularly scheduled meeting following receipt of Your request. In special circumstances, a delay until the third regularly-scheduled meeting following receipt of Your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of Your claim has been reached, You will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

This second level of appeal is completely voluntary; it is not required by the Plan and is only available if You (or Your representative) request it. Regarding voluntary appeals:

- The Plan will not assert a failure to exhaust administrative remedies because You or Your authorized representative elect not to pursue a claim through the voluntary level of appeal;
- Where You or Your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations (or other defense based on timeliness) applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after You (or Your representative) have pursued the appropriate mandatory appeals process required by the Plan;
- Upon Your request, the Plan will provide You (or Your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including a statement that the specific information regarding the process for selecting a decision-maker and any circumstances may affect the impartiality of the decision-maker.

The Plan will not impose fees or costs on You (or Your representative) if you or your authorized representative chooses to invoke the optional appeals process. Note that this voluntary level of appeal has no effect on the claimant's right to any other benefits under the Plan.

External Appeals Procedures

You have the right to file for external review of an adverse benefit determination within 4 months after receipt of the notice of the adverse benefit determination denying your appeal. For purposes of external review eligibility, an *adverse benefit determination* is a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, it is determined that the treatment is experimental or investigational or does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is an adverse benefit determination.

Any request for external review must be in writing and submitted to the Fund Office, within four months after receipt of the notice of the adverse benefit determination denying your appeal.

Within 5 business days following the date of receipt of the request, the Trustees, or their designee, must provide a preliminary review determining: if you were covered under the Plan at the time the service was requested or provided, that the determination does not relate to eligibility, that you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for External Review. Within one business day after completion of the preliminary review, the Trustees will issue to you a notification in writing.

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 Trustees must allow you to perfect the request for External Review within the four month filing period or within the 48 hour period following receipt of the notification, whichever is later.

Upon application and approval of the request for external review, the Fund Office will assign an independent review organization ("IRO").

The external review will be made by an IRO with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews (described below) this external review is available once you have exhausted the internal appeal process.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, information that the IRO may consider when conducting the External Review. The IRO may also review additional records, including, but not limited to, your medical records and the terms of the Plan.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver notice of the Final External Review Decision to you and the Plan.

Note, you may make a request for an expedited external review at the time you receive:

An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health 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 you received emergency services, but have not been discharged from the facility.

Upon a determination that a request is eligible for expedited External Review, the Trustees will assign an IRO. The IRO shall render a decision as expeditiously as your 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 IRO's decision is not in writing, within 48 hours after the date of providing that decision, the assigned IRO must provide written confirmation of the decision to you and the Plan.

SCHEDULE OF INSURANCE BENEFITS

The following schedule summarizes the various types and maximums of insurance benefits available to You or Your beneficiary while You are eligible under the Plan. Please note that the following insurance benefits do not include any other benefits that You may be eligible for under the Wage Replacement Account, detailed in the section entitled "Wage Replacement Account Benefits".

Life Insurance Fully-Insured by: Prudential Life Insurance Company of America	$25,000
Accidental Death and Dismemberment (AD&D) Self-Funded and Administered by the Fund Office	$25,000 (Principal Sum)
Supplemental Disability Self-Funded and Administered by the Fund Office	$200 per week less FICA. Maximum of 26 weeks (or 20 weeks if eligible for IMPACT Program benefit.) within a 52-week cycle, during any one period of disability.