

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the Trustees at the Fund Office as soon as possible. Deadlines for filing written appeals are as follows:

- ❖ within 180 days from the date of a decision for ***health care*** or ***Loss of Time Benefit*** claims; or
- ❖ within 60 days from the date of a decision for ***death*** or ***AD&D benefit*** claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- ❖ submit additional materials, including comments, statements or documents; and
- ❖ request to review all relevant information (free of charge).

In addition, if your claim is for health care or Loss of Time Benefits and is denied based on:

- ❖ an internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and
- ❖ a Medical Necessity, Experimental treatment or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

You may request a hearing (in person or by representative). If you don't request a hearing, this will be considered a waiver of your right to do so and the Trustees will proceed to consider your appeal based on the written information submitted.

If you do request a hearing, you will be notified in writing, of the date, time and place of the hearing. At the hearing, you or your authorized representative is entitled to appear. You will have the right to present any additional information not previously submitted. If you request a hearing and do not appear at the hearing (without requesting a continuance), the Trustees will proceed to consider your appeal based on the written information submitted.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, within five calendar days after a decision on your appeal is made.

Appeal Timeframes

The Plan's determination on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims as shown below:

Health Care Claims. A determination will be made within 60 days from receipt of your appeal. However, the determination may be made at the Fund's next quarterly meeting if the appeal is received within 30 days of that meeting.

Loss of Time Benefit Claims. A determination will be made within 45 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 45 days), a decision will be made within 90 days after the date the Plan receives your request for review. However, the Plan may:

- make its decision at the next quarterly meeting of the Board of Trustees; or
- if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

Death and AD&D Benefit Claims. A determination will be made within 60 calendar days from receipt of your appeal. If special circumstances require an extension of time (up to 60 days), a decision will be made within 120 days after the date the Plan receives your request for review. However, the Plan may:

- make its decision at the next quarterly meeting of the Board of Trustees; or
- if your appeal is received within 30 days of the meeting, make the decision at the following quarterly meeting.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

- ❖ has appropriate training and experience in the field of medicine involved in the medical judgment; and
- ❖ was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of your appeal.

Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- ❖ the specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- ❖ a statement notifying you that you have the right to request a free copy of all documents, records and relevant information;
- ❖ information relating to any additional voluntary appeal procedures offered by the Plan; and
- ❖ a statement that you may bring a civil action suit under ERISA.

In addition, for **health care** and **Loss of Time Benefit** claims the notice will include:

- ❖ a copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request; and
- ❖ a copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

The Trustees' decision is final and binding.