ARTICLE VIII – CLAIM AND APPEAL PROCEDURES

Section 8.01 - Claims Procedure

The following rules apply to claims:

(a) Timing of Notice of Denial of Claims Other Than Disability Claims

If a claim, except for a claim for disability benefits, is wholly or partially denied, the Plan Administrator shall notify the claimant, in accordance with subsection (d) of this Section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(b) Timing of Notice of Denial of Disability Claims

A claim for disability benefits includes an initial claim for disability benefit or any rescission of coverage of a disability benefit.

In the case of an adverse benefit determination concerning disability benefits, the Plan Administrator shall notify the claimant, in accordance with subsection (d) of this Section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30 day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) Calculation of Time

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

(d) Content of Notice

The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR §2520.104b-1(c)(1)(i), and (iv).

Before the Plan can issue a notice of benefit determination based on new or additional evidence, the Fund must provide the Claimant, 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 must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a notice of benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of benefit determination is required to be provided, to give the claimant a reasonable opportunity to respond prior to that date.

The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review; and

(5) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request or, if applicable, a statement that such rule, guideline, protocol or other criterion does not exist;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

With respect to an adverse benefit determination regarding disability benefits, the determination must also include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;
(ii) The advice of the health professional obtained by the Plan; or
(iii) A disability determination from the Social Security Administration.

(2) A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

(3) If the denial was based on medical necessity or experimental treatment, the denial must include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claim or statement or a statement that such explanation will be provided free of charge upon request.

(4) The denial must be in a culturally and linguistically appropriate manner.

Section 8.02 - Appeals Procedure

The following rules apply to claims:

(a) The claimant shall have 60 days (180 days for appeals involving disability benefits) following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(b) The claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as that term is defined at 29 CFR §2560.503-1(m)(8), to the claimant's claim for benefits;

(d) The review on appeal shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(e) The Trustees shall make a benefit determination no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant, in accordance with subsection (i) of this Section, of the benefit determination as soon as possible, but not later than five days after the benefit determination is made;

(f) The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to subsection (f) of this Section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information;

(g) Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;

(h) Before the Fund can a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and

(i) The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. Any electronic notification shall comply with appropriate regulations. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant;

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) 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, as that term is defined at 29 CFR §2560.503- 1(m)(8), to the Claimant's claim for benefits;

(4) A statement of the claimant's right to bring an action under Section 502(a) of ERISA;

(5) A statement describing any contractual limitation period that applies to the Claimant’s right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitations expires;

(5) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request or, if applicable, a statement that such rules or guidelines do not exist; or

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical

judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) The following statement: "You and your plan may have other 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."

In addition to the above, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

(1) An explanation of the basis for disagreeing with any of the following:

(i) The health care professionals that treated the Claimant;

(ii) The advice of the health professional obtained by the Plan; or

(iii) A disability determination from the Social Security Administration.

(2) The benefit denial must be in a culturally and linguistically appropriate manner.

Section 8.03 - Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret Plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

Section 8.04 - Timely Submission of Appeals

All appeals must be timely submitted. A Participant or dependent who does not timely submit an appeal waives his/her right to have the benefit denial further reviewed by the Fund or in a court of law.

Section 8.05 - Limitation of Actions

No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

Section 8.06 - Facility of Payment

In the event that the Board determines that a payee is mentally or physically unable to give valid receipt for any benefit due to him under the Plan, such payment may, unless claim shall have been made therefore by a legally appointed guardian, or other legal representative, (by power of attorney or otherwise) be paid to any person or institution then in the judgment of the Board providing for the care and maintenance of such payee. Any such payment shall be a payment for the account of the person involved and shall be a complete discharge of any liability of the Plan or the Board therefore.

Section 8.08 - Failure to Follows Claims Procedures

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

In addition to the above, if the plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the claimant chooses to pursue remedies under section ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant**.**

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

Section 8.09 - Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.