Appendix B

CLAIMS PROCEDURE

The general procedures for claims regarding eligibility are set forth in Section 17 A. of the Plan. The procedures described in this Appendix B shall apply to the extent that claims and appeals procedures are not set forth in the evidence of coverage documents or plan documents for component benefit programs listed in Appendix A and the Attachments.

For purposes of this Appendix B, "Claimant" means the individual seeking benefits under the Plan, or his or her representative who is authorized in writing by that individual to act on his or her behalf.

Authorized Representatives

Any of the actions to be taken, including filing the claim or requesting review, may be taken by a representative authorized in writing to act on the Claimant's behalf. If a representative is authorized to act on the Claimant's behalf, then all matters will be communicated with the authorized representative.

Form of Plan Administrator's Response

The Plan Administrator and/or claims administrator may establish such rules, policies and procedures, consistent with ERISA and the Plan, as it may deem necessary or appropriate in carrying out its duties and responsibilities under this Section. The Plan Administrator's and/or claim's administrator's response to a claim will be in written or electronic form, as set forth under the Department of Labor Regulation Section 2520.104(b)-1(c)(1).

Voluntary Level of Appeal

If an insurer, HMO provider, third party administrator, or other similar provider has a voluntary level of appeal that the Claimant utilizes, then the time periods set forth below shall be deemed to be automatically adjusted for such voluntary level of appeal in accordance with the applicable Department of Labor Regulation.

Time Limits for Claims for Benefits and Decision of Claims and Appeals

Type of Claim	Time Limits	
URGENT HEALTH CARE CLAIM		
Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject the Claimant to severe pain. The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.	**THE INITIAL CLAIM**	
	Step 1:	The Plan has **72 hours** after receiving the initial claim to approve or deny the claim.
	IF THE CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has **24 hours** after receiving the initial claim to notify the Claimant that the claim is improper or incomplete.
	Step 2:	The Claimant has **48 hours** after receiving notice from the Plan to correct or complete the claim.
	Step 3:	The Plan has **48 hours** to notify the Claimant if the claim is approved or denied. The Plan must do so within the earlier of 48 hours of: The Plan's receipt of the completed claim, or The deadline to complete the claim.
	APPEAL OF A DENIED CLAIM	
	Step 1:	If denied, the Claimant has **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 2:	The Plan has **72 hours** after receiving the appeal to notify the Claimant of its appeal decision.

PRE-SERVICE HEALTH CLAIM		
Group health claims where treatment must be precertified before it is performed.	**THE INITIAL CLAIM**	
	Step 1:	The Plan has **15 days** after receiving the initial claim to notify the Claimant if the claim is approved or denied.
	IF THE CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has **5 days** after receiving the initial claim to notify the Claimant that the claim is an improper claim.
	Step 2:	If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has **30 days** after receiving the claim to notify the Claimant of its decision.
	Step 3:	The Claimant has **45 days** after receiving the extension notice to provide additional information or complete the claim. (The time the Plan waits for Claimant information is not counted in totals.)
	APPEAL OF A DENIED CLAIM	
	Step 1:	If the claim is denied, the Claimant has **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 2:	The Plan has **30 days** after receiving the appeal to notify the Claimant of the appeal decision.
POST-SERVICE HEALTH CLAIM		
Health claims where the Claimant requests reimbursement after treatment has been performed.	**THE INITIAL CLAIM**	
	Step 1:	The Plan has **30 days** after receiving the initial claim to notify the Claimant if the claim is denied.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	The Plan has **30 days** after receiving the initial claim to notify the Claimant if the claim is denied. If the Plan Administrator determines that an extension is necessary due to matters beyond the control of the Plan and provides an extension notice during the initial 30-day period, the Plan has **45 days** after receiving the claim to notify the Claimant if the claim is denied.
	Step 2:	The Claimant has **45 days** after receiving the extension notice to provide additional information or complete the claim. (The time the Plan waits for Claimant information is not counted in totals.)
	APPEAL OF A DENIED CLAIM	
	Step 1:	If the claim is denied, the Claimant has **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 2:	The Plan has **60 days** after receiving the appeal to notify the Claimant of the appeal decision.

CONCURRENT HEALTH CARE CLAIM	
A claim where a course of	**YOUR INITIAL CLAIM**

<table>
<tr><td rowspan="5">health care treatment is reduced or terminated before the end of the period of time or number of treatments previously approved.</td><td colspan="2">The Claims Administrator will notify the Claimant sufficiently in advance of the reduction or termination to allow the Claimant to appeal the decision and have the appeal decided before the benefit is reduced or terminated.</td></tr>
<tr><td colspan="2">If the claim is an urgent care claim, and the Claimant requests an extension of the treatment beyond the approved period of time or number of treatments, then the Claims Administrator will notify the Claimant of its decision on the claim within 24 hours after receipt of the claim, provided that the claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.</td></tr>
<tr><td colspan="2">APPEAL OF A DENIED CLAIM</td></tr>
<tr><td>Step 1:</td><td>If the claim is denied, the Claimant has 180 days after receiving the claim denial to appeal the Claims Administrator’s decision.</td></tr>
<tr><td>Step 2:</td><td>The Claims Administrator has 60 days after receiving the appeal to notify the Claimant of the appeal decision.</td></tr>
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DISABILITY BENEFITS CLAIM
THE INITIAL CLAIM
The Plan has **45 days** after receiving the initial claim to notify the Claimant if the claim is denied.
IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION
The Plan may notify the Claimant within the initial **45 days** after receiving the initial claim of the need for an extension of up to **30 days** to review the claim and render a decision, and why the extension is needed, and may notify the Claimant within that extension period of the need for an additional extension of up to another **30 days**, and the reason why. If the Plan needs more information, then the Claimant will be notified of the specific information needed and the Claimant will have **45 days** to provide the specified information. Any decision period or extension period will be delayed from the date of notice to the Claimant that more information is needed to the date the Claimant supply the information.
APPEAL OF A DENIED CLAIM
If the claim is denied, then the Claimant has **180 days** after receiving the claim denial to appeal the Plan’s decision.
The Plan has **45 days** after receiving the appeal to notify the Claimant of the appeal decision. If the Plan needs an extension due to special circumstances for processing the appeal, the Claimant will be notified within the initial 45 days of the need for an extension and the date the review will be completed, which will not be later than **90 days** after receipt of the request for review.

Content of Notice of Denial of a Claim

If the claim is wholly or partially denied, then such notice shall set forth: the specific reason(s) for the denial; reference to the specific Plan provision(s) on which the denial is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the rights

to bring a civil action under ERISA Section 502(a), following the denial of a claim on review; if an internal rule, guideline, protocol, or other criterion (other than that which is legally-privileged) was relied upon in making the adverse determination, then 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 denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; if the denial is based on medical necessity or experimental treatment, then the denial notice an explanation of the scientific or clinical judgment for the determination, applying Plan terms to the medical condition; and, if the denial is for an urgent care claim, then a description of the expedited review process applicable to such claims.

Procedure for Appeal of a Denied Claim

If the claim is denied, then the Claimant has the right to appeal the denial within 180 days after receiving the claim denial. If the Claimant appeals, the Claimant has the right to review pertinent documents (other than legally privileged documents) and to submit issues and comments in writing. The request for review should set forth all of the grounds upon which it is based, all facts in support of the request and any other matters that the Claimant deems pertinent. In addition, the Claimant may be required to submit such additional facts, documents or other material. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision. If the claim involves urgent care, then a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Plan and the Claimant by telephone, fax, or other similar method.

If the claim on appeal is wholly or partially denied, then such notice shall set forth: the specific reason(s) for the decision and reference(s) to the Plan provision(s) or other governing Plan documents on which the decision is based; a statement indicating that the Claimant is entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information (other than legally privileged documents) relevant to the determination; a statement describing any voluntary appeal procedures offered by the Plan and the right to obtain information about these procedures; a statement of the rights to bring a civil action under ERISA Section 502(a), following the denial of a claim on review; a statement disclosing any internal rule, guideline, protocol, or other similar criterion (other than that which is legally-privileged) relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request); a statement that ”You or 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”; if the denial on appeal is based on medical necessity or experimental treatment, then an explanation of the scientific or clinical judgment for the determination, applying Plan terms to the medical condition or that such information will be provided free of charge upon request.