

UNIVERSITY OF ROCHESTER
CLAIMS AND APPEALS PROCEDURES FOR NON-PENSION BENEFITS

ELIGIBILITY CLAIMS PROCEDURES

Any participant (employee) or beneficiary (dependent), or an authorized representative acting on behalf of a participant or beneficiary, may assert a claim for eligibility. Throughout this section, any of these individuals are referred to generically as a “Claimant.”

The following procedures shall apply if a Claimant is inquiring about eligibility to participate in a Program. These rules do not apply if a Claimant is also claiming the right to receive benefits under a Program rather than just inquiring about eligibility. If a Claimant is also filing a claim for benefits, the Claimant shall use the Benefits Claims Procedures that apply to the particular Program under which the claim is being brought, as described in the following section.

A. Determination of Benefits

A claim for eligibility must be submitted to the University of Rochester Benefits Office (the “Benefits Office”) in writing. The Benefits Office will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Benefits Office determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Benefits Office will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Benefits Office expects to render a decision.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Benefits Office will provide the Claimant, within the time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions upon which the benefit determination is based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary; and
- a description of the Plan’s appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA (if applicable) if the claim continues to be denied on review.

C. Appeal of Adverse Claim Determination

If the claim for eligibility is denied by the Benefits Office, the Claimant may submit a written appeal to the Manager of the Benefits Office (the “Manager”) requesting a review of the decision. The written appeal must be submitted within 60 days of the Claimant receiving the initial adverse decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Benefits Office’s decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Manager will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Manager will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the adverse determination;
- references to the specific Plan provisions on which the determination was based;
- a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant’s benefit claim upon request; and
- a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA (if applicable).

BENEFITS CLAIMS PROCEDURES

Any participant (employee) or beneficiary (dependent), or an authorized representative acting on behalf of a participant or beneficiary, may assert a claim for benefits. Throughout this section, any of these individuals are referred to generically as a “Claimant.”

All claims for benefits under a particular benefit Program described in this booklet should be submitted in accordance with the terms of that Program as described in the benefits booklets or other materials from the Third Party Administrator (TPA) and will be subject to the claims review procedure for that Program. However, if the particular issue on which a claim is based does not relate to any Program, or if the Program materials lack a claims procedure that satisfies any then-applicable ERISA claims procedure requirements, then the relevant claims procedures below shall apply or shall supplement the defective claims procedures to bring them into compliance. Where a Program’s materials with a defective claims procedure specify that claims can be filed or must be responded to in a time period more generous to the Claimant than the procedures below, then these procedures shall also be read to require the more generous time period for submission or response.

The “Claims Reviewer” is the individual or entity assigned to review claims or appeals for a Program. Where a Program’s materials specify that claims be sent to an insurer or TPA, then the insurer or TPA shall be the Claims Reviewer for purposes of the procedures that follow. Where a Program’s materials do not contain any claims procedure, then the following procedures shall apply.

The applicable Claims Reviewers for the Programs described in this booklet are listed below:

| Benefit | Claims Reviewer |
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| Health Plan (if Aetna is the health care TPA) | Aetna 1-877-864-4583 www.aetna.com The denial notice will include the address where the appeal can be sent. |
| Health Plan (if Excellus BlueCross BlueShield is the health care TPA) | Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 1-800-659-2808 or 1-585-232-2632 www.excellusbcbs.com/ur The denial notice will include the address where the appeal can be sent. |

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| <p>Dental Plan</p> | <p>Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 1-800-724-1675 www.excellusbcbs.com/ur www.rochester.edu/benefits/dental</p> <p>The denial notice will include the address where the appeal can be sent.</p> |
| <p>Prescription Drug Plan (if Excellus BlueCross BlueShield is the health care TPA)</p> | <p>Excellus BlueCross BlueShield 165 Court Street Rochester, NY 14647 1-877-391-9296 www.excellusbcbs.com/ur</p> <p>The denial notice will include the address where the appeal can be sent.</p> |
| <p>Prescription Drug Plan (if Aetna is the health care TPA)</p> | <p>Aetna 1-877-864-4583 www.aetna.com</p> <p>The denial notice will include the address where the appeal can be sent.</p> |
| <p>Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA (if Aetna is the health care TPA)</p> | <p>Aetna FSA P.O. Box 4000 Richmond, KY 40476-4000 1-888-238-6226 Fax: 1-888-238-3539 www.aetnafsa.com</p> <p>Reimbursement forms are available from the UR Benefits Office or can be printed from www.rochester.edu/benefits/fsa. Claims can be faxed directly to 1-888-AETFLEX (238-3539).</p> |

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| <p>Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA (if Excellus is the health care TPA or the participant does not have University health care)</p> | <p>Lifetime Benefits Solutions, Inc. Claims Dept. P.O. Box 680 Liverpool NY 13088 Fax: 1-877-256-7228</p> <p>Reimbursement forms are available from the UR Benefits Office or can be printed from www.rochester.edu/benefits/fsa. Claims can also be submitted online at https://ebrparticipant.lh1ondemand.com. After submitting claims online, all receipts and supporting documentation must be faxed to Lifetime Benefits Solutions, Inc. at 1-877-256-7228.</p> |
| <p>Behavioral Health Partners</p> | <p>1-585-276-6900 http://www.bhp.urmc.edu</p> |

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| <p>Lifestyle Management Program, Disease Management Program, Well U, Employee Assistance Program, Severance Pay for Staff of the University of Rochester, University of Rochester Death Benefit Gratuity, or any other claims related to Group Health Plan benefits</p> | <p>UR Benefits Office 60 Corporate Woods, Suite 310 PO Box 270453 Rochester, NY 14627 585-275-2084 Facsimile 273-1054 benefitoffice@hr.rochester.edu www.rochester.edu/benefits</p> <p>Requests for benefits should be made by contacting the appropriate administrator listed on page 1. Claimants who are dissatisfied with the administrator's response may file a formal claim with the Benefits Office. The Manager of the Benefits Office will review all appeals.</p> |
| <p>Long-Term Disability Plan for Faculty and Staff of the University of Rochester</p> | <p>Standard Life Insurance Company of New York 360 Hamilton Avenue, Suite 210 White Plains, NY 10601-1871 (914) 989-4400</p> <p>Note: For initial claims, notify the University of Rochester Benefits Office at 585-275-2084, who will initiate the claims process with Standard on your behalf.</p> |
| <p>LTD Plan for Staff of the University of Rochester Who Are Members of SEIU</p> | <p>Standard Life Insurance Company of New York 360 Hamilton Avenue, Suite 210 White Plains, NY 10601-1871 (914) 989-4400</p> <p>Note: For initial claims, notify the University of Rochester Benefits Office at 585-275-2084, who will initiate the claims process with Standard on your behalf.</p> |
| <p>Long-Term Disability for Residents of the University of Rochester</p> | <p>The Guardian Life Insurance Company of America Group LTD Claims P.O. Box 26025 Lehigh Valley, PA 18002-6025 1-800-538-4583</p> <p>Note: For initial claims, notify the University of Rochester Benefits Office at 585-275-2084, who will initiate the claims process with Guardian on your behalf.</p> |

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| <p>Group Life Insurance Plan for Faculty and Staff of the University of Rochester</p> | <p>Securian 400 Robert Street North, St. Paul, MN 55101-2098 1-800-815-7636</p> <p>Note: For initial claims, notify the University of Rochester Benefits Office at 585-275-2084, who will initiate the claims process with Securian on your behalf. The Death Benefit Gratuity is administered by the University of Rochester Benefits Office.</p> |
| <p>Long-Term Care Plan for Faculty and Staff of the University of Rochester</p> | <p>CNA/Continental Casualty Company 333 South Wabash Avenue Chicago, IL 60604 1-877-430-5824</p> |
| <p>Travel Accident Insurance for Faculty and Staff of the University of Rochester</p> | <p>Federal Insurance Company 202 Hall's Mill Road P.O. Box 1600 Whitehouse Station, NJ 08889-1600 <i>Medical and Travel Assistance Services:</i> 1-866-832-6930 or 410-453-6330 <i>Identity Theft Protection:</i> 1-866-299-7277 <i>To initiate all other claims call University Benefits Office:</i> 585-275-2084</p> |

DEFAULT CLAIMS PROCEDURES FOR GROUP HEALTH PLANS (HEALTH PLAN, PRESCRIPTION DRUG PLAN, DENTAL PLAN, HEALTH CARE FSA, LIMITED PURPOSE HEALTH CARE FSA, LIFESTYLE MANAGEMENT PROGRAM, DISEASE MANAGEMENT PROGRAM, EMPLOYEE ASSISTANCE PROGRAM, TRAVEL ACCIDENT INSURANCE CLAIMS FOR MEDICAL CARE, AND LONG-TERM CARE PLAN CLAIMS FOR MEDICAL CARE)

This procedure applies only to claims submitted for Group Health Plan benefits under a Program. In addition, it applies to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals for Group Health Plan benefits will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the claims an appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

Certain aspects of the claims procedures apply only to Plans that are not grandfathered medical plans under 26 CFR § 54.9815-1251T and that are subject to the expanded claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA). Those sections are indicated throughout the procedures that follow. In cases where the Department of Labor has indicated that there is a delayed enforcement deadline for a particular PPACA requirement described in this section, the Plan Administrator or Claims Reviewer may delay implementation of the particular delayed provision until the enforcement deadline.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

The following terms are defined for purposes of this subsection:

- *Post-Service Claim* means any claim for a benefit which is not a Pre-Service Claim as defined below. Most Health Care FSA and Limited Purpose Health Care FSA claims are considered Post-Service Claims.

- *Pre-Service Claim* means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care (e.g. if the Plan requires precertification in order for a service to be covered).
- *Urgent Care Claim* means a claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
 - could seriously jeopardize the Claimant's life or health or the ability of the Claimant to regain maximum function, or
 - in the opinion of a physician 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.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care.

- *Group Health Plan or Plan* means, for purposes of this claims procedure, any Program described in the Health Program Decision Guide that is a group health plan as defined by ERISA, which generally means that the Program provides benefits for health care or treatment.
- *Claims Reviewer* means the person or entity responsible for the relevant claims determination under the Plan.
- *Appeals Unit* means the group or individuals employed by the Claims Reviewer assigned to review appeals of adverse benefit determinations.
- *Non-Grandfathered Health Plans* means the Health Plan, Prescription Drug Plan, and Disease Management Program.

I. Internal Review

A. Determination of Benefits

A claim for Health Plan, Dental Plan, or Prescription Drug Plan benefits is generally submitted by the Claimant's health care provider. Health Care FSA claims are submitted automatically by the Claimant's health care provider if the Claimant is enrolled in a University Health Plan and has not opted out of Automatic Claims Transfer. Out-of-network claims for Health Plan, Dental Plan, or Prescription Drug Plan benefits, and Health Care FSA or Limited Purpose Health Care FSA claims may be submitted manually by the Claimant in writing. The amount of time that the Claims Reviewer has to respond to a claim for benefits will depend upon the type of claim for benefits being made, as provided below.

- *Post-Service Claims:* The Claims Reviewer will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Claims Reviewer expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a benefit determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Claims Reviewer.
- *Pre-Service Claims:* The Claims Reviewer will notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the claim. This period may be extended for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Claims Reviewer expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information received by the Claims Reviewer. In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within five days after the Claims Reviewer initially receives the claim so that the Claimant can make proper adjustments.
- *Urgent Care Claims:* The Claims Reviewer will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Reviewer will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the claim (in the case of non-grandfathered health plans subject to the

expanded claims procedure requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim), unless the Claimant fails to submit information necessary to decide a claim. In this situation, the Claimant will be informed within 24 hours after submitting the claim the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Claims Reviewer's receipt of the requested information or the end of the period the Claimant was given to supply the additional information. In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within 24 hours after the Claims Reviewer initially receives the claim so that the Claimant can make proper adjustments.

- *Concurrent Care Decisions:* In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated. If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant, within the relevant time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- references to the specific Plan provisions on which the benefit determination was based;

- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of the Plan's internal appeals procedures, any applicable the external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on 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 particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- the contact information for the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth above shall follow within three days.

C. Appeal of Adverse Claim Determination

If the claim is denied in whole or in part, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the claim free of charge. In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his or her claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Claims Reviewer's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Appeals Unit of the Claims Reviewer. The Appeals Unit will not have been involved in the initial benefit determination nor will the reviewer within the Appeals Unit be a subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

After an appeal is filed, the Claims Reviewer will respond to the claim within a certain period of time. The amount of time that the Claims Reviewer has to respond is based on the underlying claim for benefits as set forth below:

- *Post-Service Claims:* within a reasonable period, but no more than 60 days after receiving Claimant's appeal request.
- *Pre-Service Claims:* within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving Claimant's appeal request.
- *Urgent Care Claims:* as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving Claimant's appeal request (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim).

D. Interim Notification of New Evidence or Rationale During Pendency of Interim Appeal

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, if during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

E. Notification of Final Internal Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- references to the specific Plan provisions on which the benefit determination was based;

- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on 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 particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- a discussion of the decision to deny the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);
- disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and
- a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

II. External Review

The following review procedures apply to non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA. Specifically, they apply to such plans that are self-insured. Fully-insured group health Plans subject to external review requirements are generally subject to applicable state external review procedures, as outlined in each Plan. However, in the event those state external review procedures do not comply with PPACA requirements by the enforcement deadline imposed by the Departments of Labor and Health and Human Services, then such fully-insured Plans will be governed by these procedures to the extent necessary to comply with PPACA.

These procedures are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01, Department of Labor Technical Release 2011-02, and 76 Fed. Reg. 37208-37234 (June 24, 2011). At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with PPACA.

A. Standard External Review

This Section II.A. describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described in Section II.B., below).

- 1. Requests for External Review.** A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. Except for requests for external review initiated before September 20, 2011, external review is only available for:

- a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
- an adverse benefit determination (including a final adverse benefit determination) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:
 - the appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
 - whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
 - whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
 - a determination that a medical condition is a preexisting condition;
 - the Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
 - whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;
 - the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
 - whether the Plan is complying with the nonquantitative treatment limitation provisions of

the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

2. Preliminary Review. Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:

- the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
- the Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and
- the Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

3. Referral to Independent Review Organization. The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally-recognized accrediting organization to conduct the external review. The Claims Reviewer will contract for assignments under the Plan with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

- The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

- The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.
- Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - the Claimant's medical records;
 - the attending health care professional's recommendation;

- reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;
 - the terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;
 - appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and
 - the opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.
- The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:
 - a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;
 - a discussion of the principal reason or reasons for its decision, including the rationale for its decision

and any evidence-based standards that were relied on in making its decision;

- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;
- a statement that judicial review may be available to the Claimant; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

4. Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

B. Expedited External Review

1. Request for Expedited External Review. When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

- 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 the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or
- a final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life

or health of the Claimant or would jeopardize the Claimant's 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 the Claimant receive emergency services, but has not been discharged from a facility.

2. **Preliminary Review.** Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in Section II.A.2. above for Standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section II.A.2. for Standard External Review to the Claimant of its eligibility determination.
3. **Referral to Independent Review Organization.** Upon determination that a request is eligible for expedited external review following preliminary review described in Section II.B.2. above, the Claims Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in Section II.A.3. above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. **Notice of Final External Review Decision.** The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of Section II.A.3.f. above for Standard External Review, except that the notice will be provided as expeditiously as the Claimant's 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 notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.
5. **Reversal of Plan's Decision.** Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies

are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. IRO Recordkeeping Requirements

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

DEPENDENT CARE FSA CLAIMS PROCEDURES

The following procedures apply for benefit claims under the Dependent Care FSA Program.

A. Determination of Benefits

A claim for benefits under the Dependent Care FSA must be submitted to the Claims Reviewer in writing on forms specified by the Claims Reviewer. The Claims Reviewer will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Claims Reviewer determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Claims Reviewer will notify the Claimant, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Claims Reviewer expects to render a decision.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant, within the time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions upon which the benefit determination is based;

- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary; and
- a description of the Plan's appeals procedures and applicable time limits.

C. Appeal of Adverse Claim Determination

If the claim is denied in whole or in part, the Claimant may submit a written appeal to the Claims Reviewer requesting a review of the decision. The written appeal must be submitted within 60 days of the Claimant receiving the initial adverse decision. The appeal should clearly state the reason or reasons why the Claimant disagrees with the decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Claims Reviewer will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Claims Reviewer will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the adverse determination; and
- references to the specific Plan provisions on which the determination was based.

DEFAULT CLAIMS PROCEDURES FOR DISABILITY PLAN CLAIMS PROCEDURES (LONG-TERM DISABILITY FOR RESIDENTS OF THE UNIVERSITY OF ROCHESTER, LTD PLAN FOR STAFF OF THE UNIVERSITY OF ROCHESTER WHO ARE MEMBERS OF SEIU, LONG-TERM DISABILITY PLAN FOR FACULTY AND STAFF OF THE UNIVERSITY OF ROCHESTER)

A claim for disability benefits is initiated by contacting the University of Rochester Benefits Office, who will initiate the claim with the applicable Claims Reviewer.

A. Determination of Benefits

The Claimant must complete any forms and supply any information requested by the Claims Reviewer in accordance with the claims procedures for the applicable Program.

The Plan Administrator will notify the Claimant of the claim determination within 45 days of the receipt of the claim. This period may be extended by 30 days if an extension is necessary to process the claim due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and when the Plan expects to decide the claim, will be furnished to the Claimant within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension. A written notice of the additional extension, the reason for the additional extension and when the Plan expects to decide the claim, will be furnished within the first 30-day extension period if an additional extension of time is needed. All notices of extension will 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 that the Claimant will have at least 45 days to provide the requested information. If a period of time is extended due to the Claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination by the Plan Administrator will 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 or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant, within the time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions on which the benefit determination was based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of the Plan's appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on 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 particular medical circumstances; or a statement that this will be provided free of charge upon request; and

- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination.

C. Appeal of Adverse Determination

If the claim is denied in whole or in part, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant the claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the appeals unit of the Claims Reviewer. The appeals unit will not have been involved in the initial benefit determination nor will the reviewer within the appeals unit be a subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

The Claims Reviewer will make a determination on the appeal within 45 days of the receipt of the appeal request. This period may be extended for an additional 45 days if the Claims Reviewer determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Reviewer expects to render a decision will be furnished to the Claimant within the initial 45-day period. However, if the period of time is extended due to the Claimant's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which the Claimant responds to the request for additional information.

D. Notification of Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions on which the determination was based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of any voluntary review procedures and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on 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 particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the determination; and
- a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

CLAIMS FOR OTHER BENEFITS

The following procedures apply for claims for other benefits described in this booklet that are not covered by the claims procedures for the Programs set forth above, including Severance Pay, Group Life Insurance Benefits, the University of Rochester Death Benefit Gratuity, Well U claims unrelated to the Lifestyle Management Program, Travel Accident Insurance claims unrelated to medical care, and Long-Term Care claims unrelated to Medical Care. Employees may also utilize these procedures to request review of a determination regarding other non-ERISA benefits offered by the University, including the Sick Leave Plan for Short-Term disability, Paid Time Off Plan for non-exempt staff in divisions 40, 50, 60, 90, 91 & 92, Tuition Benefits, Vacation, or Holidays.

A. Determination of Benefits

Claims for other benefits described in this booklet shall be submitted to the University of Rochester Benefits Office (the “Benefits Office”) in writing. The Benefits Office will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Benefits Office determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Benefits Office will notify the Claimant in writing, and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Benefits Office expects to render a decision.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Benefits Office will provide the Claimant with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions upon which the benefit determination is based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant’s benefit claim upon request; and
- a description of the Plan’s appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA (if applicable) if the claim continues to be denied on review.

C. Appeal of Adverse Claim Determination

If the claim is denied in whole or in part, the Claimant may submit a written appeal to the Manager of the Benefits Office (the “Manager”) requesting a review of the decision. The written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why the Claimant disagrees with the Benefits Office’s decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Manager will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in

writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Claims Reviewer will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the adverse determination;
- references to the specific Plan provisions on which the determination was based;
- a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant's benefit claim upon request; and
- a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA (if applicable).

VOLUNTARY APPEAL PROCEDURES

To the extent the Plan's or a Program's claims procedures include a voluntary level of appeal, the Plan:

- waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the Plan or Program;
- agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;
- declares that a Claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the mandatory appeals permitted by ERISA claims regulations;
- shall provide to any Claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant's rights to any other benefits under the Plan or Program and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

- shall not impose any fees or costs on the claimant as part of the voluntary level of appeal.

STATUTE OF LIMITATIONS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, Claims Reviewer, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Claims Reviewer's decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. *De minimis*;
2. Not likely to cause, prejudice or harm to the Claimant;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting 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 requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.