

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

For claims other than insured claims, if you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal, you must write to the Trustees within 180 days after you receive the Plan's initial adverse benefit determination, except that with regard to death benefit claims, the time frame is 60 days, not 180 days. All documentation must be sent in writing to the:

***Board of Trustees
Roofers Local #195 Health & Accident Fund
6200 State Route 31
Cicero, New York 13039***

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative. In an appeal of an Urgent Care Claim, a health care professional with knowledge of your medical condition shall be permitted to act as your authorized representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will 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.

In addition, in regard to all appeals other than those involving Death Benefits: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims: For urgent care claims, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or insurance company, as applicable) by telephone, facsimile, or other similarly expeditious method.

Determinations on Appeal:

Insured Post-Service Claims: The insurance company will decide the appeal in accordance with ERISA regulations within 60 days if one (1) level of appeal is provided, or if two (2) levels of appeal are provided, within 30 days at each level.

Pre-Service Claims: You will be notified of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review. The insurance company will decide appeals of insured claims in accordance with the ERISA regulations within the same time frame (except that if the insurer provides two (2) levels of appeal, the decision has to be made within 15 days at each level).

Urgent Care Claims: You will be notified of the decision as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review. The insurance company will decide appeals of insured claims within the same time frame in accordance with ERISA regulations.

All Other Claims: The Trustees at their next regularly scheduled meeting will make a determination of the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

The Trustees' Decision is Final and Binding

The Trustees' final decision with respect to their review of any appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

No Liability for Practice of Medicine

The Plan, the Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.