Claims Procedures for Health and Welfare Benefits

In order to receive health and welfare plan benefits, you must follow the procedures established by the plan and/or the insurance company which has the responsibility for making the particular benefit payments to you.

If a request for health and welfare plan benefits is denied, you, or a beneficiary or a duly authorized representative, may file a claim for program benefits to which you believe you are entitled. For more information on the plan's claims procedures, contact your Human Resources representative.

Claims Procedure Detail

The following summary of the Plan's claims procedures incorporates the applicable requirements of regulations issued under the federal health care reform law and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures will apply instead of the claims procedures described below. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a termination of coverage that is retroactively effectively for fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the section(s) of this summary describing those benefits.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures.

A. Claims for Benefits under Medical Coverage.

(i) Urgent Care Claims. If the claim is for urgent care medical benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A medical claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant 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 could not be adequately managed without the care or treatment which is the subject of the claim. For any claim for benefits under coverage that is subject to the Affordable Care Act, the Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Medical Claims. For any medical claim not described above:

(a) For a pre-service medical claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A medical claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(b) For a post-service medical claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A medical claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

B. All Other Benefit Claims. For all claims other than medical plan claims, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond the day which is 180 days after the day the claim is filed.

C. Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed); and

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial.

In addition, for a denial of medical benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that a copy will be provided without charge upon request); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that an explanation will be provided without charge upon request).

For an adverse determination involving an urgent care claim, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

A. Medical Claims. The procedures in this section (A) apply only to medical claims. A Claimant whose initial claim for benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

The Plan's review will meet the following requirements:

(i) The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(ii) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(iii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iv) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(v) The Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following requirements:

(a) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(b) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(vi) Urgent Care Claims. For urgent care medical claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(vii) Other Medical Claims.

(a) For a pre-service medical claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(b) For a post-service medical claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event

later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination.

B. All Other Benefits. For claims other than medical claims, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after the Reviewer receives the request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

C. Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii)a description of the specific reasons for the decision; and

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based.

In addition, for medical plan claims, any notice of an adverse determination on review will include:

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;

(v) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vi) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4)information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

The Plan will make reasonable good faith efforts to comply with requirements (1) through (4) above. However, the plan will not be treated as in violation of any requirement of the Plan's claims procedures because a notice fails to satisfy all of those requirements, to the extent that an enforcement grace period applies under Department of Labor Technical Release 2011-01 (or any later guidance that extends that enforcement grace period).

Also, for all claims involving coverage that is subject to the Affordable Care Act, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for benefits (other than urgent care benefits), the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits that are not subject to the Affordable Care Act, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under applicable state law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim for benefits under coverage that is subject to the Affordable Care Act you are deemed to have exhausted the Plan's internal claims and appeals process if the Plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services), except for certain minor violations. For this purpose, the Plan's failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this "minor violation" exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon Claimant's receipt of the notice.

In cases where you are deemed to have exhausted the Plan's internal claim procedures, you have the right to pursue any available remedy under applicable state law.

External Review

A. External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

B. Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage;

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

C. Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

D. Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The Adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

E. Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving any information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO 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:

(a) The Claimant's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(d) The terms of the Plan, unless the terms are inconsistent with applicable law;

(e) 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;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the

notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(a) 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, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c)References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) 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;

(e) 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 to the Claimant;

(f)A statement that judicial review may be available to the Claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

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

E. Effect of External Review Decision. An external review decision is binding on the Plan, as well as 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 does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will 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.

Expedited External Review

A. Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims 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

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing 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 determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

B. Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Third Party Rights Regarding Your Health and Welfare Benefits Plan Information

Occasionally, third parties who are not covered persons (e.g., concerned family members) assist covered persons with maximizing their rights under the health & welfare benefits plan. CHSLI encourages the use by covered persons of all resources that will help them use the health and welfare benefits plan in the way that is best for them as covered persons.

Unfortunately, sometimes third parties attempt to enforce plan rights of covered persons for the third party's own benefit or for the benefit of some other party (such as a provider of medical services). For the protection of the plan and its participants, the plan has developed authorized representative rules to ensure that participants and other covered persons have the benefit of using representatives to assist them in using the plan, but that protects participants from third parties who are not truly representatives of the covered person. These rules require that the representative have a duty to the covered person and not to outside interests.

If you wish to have an authorized representative assist you with respect to your health and welfare benefits, please contact MyHR at 516-705-6947, to obtain an Authorized Representative Form and related authorization materials.