HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM

I. HOW TO FILE A CLAIM FOR FUND BENEFITS

A. Medical Program

Your identification card is the easiest way to file a claim for benefits under the Medical Program. Generally, a health care provider will submit medical claims on a Member or Dependent's behalf in accordance with the information on the membership card.

If the Plan requires pre-certification in order to obtain a medical procedure, providers should contact the applicable Claims Administrator at the telephone number found on the reverse side of the Member's or Dependent's membership card. Most in-network providers will obtain pre-certification of medical procedures on behalf of the Member or Dependent but it is ultimately the responsibility of the Member or Dependent, as applicable, to make sure that pre-certification is obtained. See the applicable Summary of Benefits Schedule for information on which medical procedures the Plan requires pre-certification.

You may appoint an authorized representative to act on your behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Fund as your authorized representative should contact the Fund office.

B. Dental Benefits

All that is generally needed to obtain the dental benefits the Plan provides is to have the dentist submit a claim to the Fund. Generally, a Member's dentist will submit dental claims on the Member or Dependent's behalf in accordance with the information on the dental plan identification card. Additionally, a dental claim form can be obtained from the Fund office or may be printed off from the Fund's website at *www.teamsterfunds.com*.

C. Prescription Drug Benefits

The pharmacy benefits identification card is the easiest way to file a claim for prescription benefits. Generally, the pharmacy will submit claims on a Member or Dependent's behalf in accordance with the information on the pharmacy benefits identification card.

D. Vision Benefits

The vision benefits identification card is the easiest way to file a claim for vision benefits. Generally, the provider will submit claims on a Member or Dependent's behalf in accordance with the information on the vision benefits identification card.

E. Life and AD&D Benefits

Once the Fund office is notified of a death, it will send the appropriate forms to the beneficiary on record.

1. **Death or Dismemberment of the Participant** - Complete the form and attach a certified copy of the death certificate as well as any other requested information.

2. **Death of Spouse** - Complete the form and attach a certified copy of the death certificate as well as any other requested information, including a copy of the marriage certificate.

3. **Death of a Child** - Complete the form and attach a certified copy of the death certificate along with any other requested information, including a copy of the child's birth certificate or other documents conferring parental rights to you under applicable law (e.g., a court order confirming an adoption of a child).

4. **For Member Total Disability Extended Life Insurance Benefits** – Complete the form and attach a certified copy of the death certificate as well as any other requested information.

F. Weekly Disability Benefits

To apply for weekly disability benefits, the Fund's disability benefit claim form must be completed in its entirety. There are three sections to this form; claimant (Member), Provider, and Employer (Company) Statement. The treating Provider must complete his or her section of the form and your Employer must also complete the Company Statement section of the claim form.

G. Behavioral Health Program

The behavioral health benefits identification card is the easiest way to file a claim for behavioral health benefits. Generally, the provider will submit claims on a Member or Dependent's behalf in accordance with the information on the behavioral health benefits identification card.

H. Health Reimbursement Arrangement

See the Health Reimbursement Arrangement Benefit section in the Enhanced Benefits Guide for information on how to file claims for reimbursement under the HRA.

II. ASSIGNMENT OF BENEFITS STATEMENT

Except in the case of self-insured benefit (which cannot be assigned), if the Fund is to make payment to an applicable service provider (if permitted under the Plan), sign the appropriate "Assignment of Benefits Statement" contained on the claim form. If payment is to be made to a Member or Dependent, attach an original, itemized bill (not a copy) to the claim form, along with a paid receipt to verify charges and payment. The service provider should provide a detailed bill listing the following: diagnosis, dates of treatment, treatment performed, and charges for each treatment.

III. HOW SOON SHOULD YOU FILE YOUR CLAIM?

For claims under all benefits offered under the Plan, you must submit to the Fund written proof of loss or claim within one year after the date of such loss or claim. Failure to furnish said proof within such time will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time but only if the Fund is not prejudiced by the late filing.

Any benefit payable for loss of the Member's life will be payable to the Member's designated beneficiary; other benefits will be payable to the Member, or, in certain cases, the Member may assign these other benefits to the applicable service provider. In the event of an overpayment, either to you or to a service provider on your behalf or on a Dependent's behalf, the Fund reserves the right to collect such overpayment by any legal means, including by reducing subsequent benefit payments by the amount of such overpayment.

No claim will be honored or payable unless the claim is received in and filed with the Fund office no later than one year from when the expense was incurred that gives rise to the claim. Unless specifically provided in an applicable insurance contract or pursuant to applicable law, a suit for benefits under the Fund must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

IV. CLAIM REVIEW / CLAIM APPEAL PROCEDURE

General Rules

The Trustees maintain reasonable claim procedures for the Fund as required by law. They have therefore established the following claims review and appeal procedures in order to adjudicate claims for Fund benefits. The Trustees and the Fund Administrator have the discretion and authority to interpret the terms of the Fund's plan documents, including without limitation to this Summary Plan Description, the Agreement and Declaration of Trust establishing this Fund and all restatements thereof, and the collective bargaining agreements establishing Contributing Employer participation in the Fund, and to determine eligibility for Fund benefits to the greatest extent permitted by applicable law.

Self-Insured Benefits

The applicable Claims Administrator for each of the self-insured benefits offered under the Plan will provide notice of a benefit determination within the following time frames:

1. Urgent Care Claims

In the case of a claim involving urgent care, the Claims Administrator will notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the claimant has failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to complete the claim. 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 Claims Administrator, as applicable will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

2. Concurrent Care Decision

If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or a number of treatments:

a) Any reduction or termination by the Claims Administrator of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Claims Administrator will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.

b) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care will be decided as soon as possible, taking into account medical exigencies, and the Claims Administrator will notify the claimant of the benefit determination, whether adverse or not, within 24 hours prior to the initially approved period of time or number of treatments, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator 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 receipt of the claim by the Claims Administrator. The Claims Administrator may extend this period one time for up to 15 days, provided the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Claims Administrator, and notifies the claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. 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 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 this specified information.

4. Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. The Claims Administrator may extend this period one time for up to 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. 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 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.

5. Disability Program Claims

In the case of a claim for disability benefits under this Plan, the Claims Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond its control, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. In the case of any extension under this paragraph, the notice 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 the claimant will be afforded at least 45 days within which to provide the specified information.

6. Notification on Denial of Claim

In the event of an adverse benefit determination, the Claims Administrator will send the claimant a written notification containing specific reasons for the adverse benefit determination. The information set forth in the notice will be provided in a manner calculated to be understood by the claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements), and will include the following:

- information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable);
- a statement of the specific reason(s) for the adverse benefit determination, including any denial code and its corresponding meaning and any Plan standard used in denying the claim;
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a statement advising the claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a description of any additional material or information necessary to perfect the claim and why such information is necessary;

- a description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Fund's claims procedures;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request;
- if the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- contact information for the Employee Benefits Security Administration of the U.S. Department of Labor and any applicable state consumer assistance program.

Life and AD&D Insurance Claims

Because the Fund's life and AD&D benefits are fully insured benefits, the insurer will notify the person seeking payment of such benefits of any adverse benefit determination and the process by which that person may seek a review of the determination under the insurance policy.

V. Right of Review (Appeals) for Self-Insured Benefits

1. Appeals of Adverse Benefit Determinations

A claimant who receives an adverse benefit determination with respect to any claim will have the right to a full and fair review of that determination as required by applicable law. For self-insured benefits, the Appeals Committee adjudicates all internal appeals. In addition, as described below, after you have exhausted the internal appeals process, you have the voluntary right to an independent external review of certain claims under the Medical Benefits Program.

2. Time Frame for Seeking Review of an Adverse Benefit Determination

A claimant may request review of an adverse benefit determination within 180 days of the claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.

3. Rules Applicable to a Review of an Adverse Benefit Determination

The following procedures apply to any review sought by a claimant concerning an adverse benefit determination under this Plan:

a) The claimant will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

b) The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. A document, record or other information is relevant to a claim if: it was relied upon in making the benefit determination; submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.

c) The review of the adverse benefit determination 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.

d) The review will not give deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.

e) If the adverse benefit determination was 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, then the appropriate Plan fiduciary will consult with a health care professional who has the appropriate training and experience in the relevant field.

f) The review process will identify the medical or vocational expert, if any, whose advice was obtained on behalf of the Plan in connection with the

claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

g) If a health care professional was consulted in connection with the adverse benefit determination, that person will not be consulted in connection with the review of the adverse benefit determination.

h) In the case of a claim involving urgent care, there will be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and all necessary information, including the Plan's adverse benefit determination on review, will be transmitted between the applicable and the claimant or claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

4. Second-Level Appeal Before Appeals Committee

In the event that a claimant is not satisfied with the outcome of its initial appeal of an adverse benefit determination, the claimant may file a second-level appeal with the Appeals Committee within 90 days of the denial of the initial appeal of the adverse benefit determination. The Appeals Committee consists of at least two trustees designated by the full Board of Trustees. The two designated trustees will have been involved in making the initial benefit decision. The review by the designated trustees will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The designated trustees will give no deference to the initial appeal decision. A claimant or claimant's authorized representative may appear before these trustees to present any evidence or argument in support of the claim review.

5. Content of Claim Review Determination

Each claim review determination will be signed by the Fund Administrator at the Claim Review Committee level, and by at least the two trustee members of the Appeals Committee authorized by the full Board of Trustees to resolve such claim review at the second level. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits; and after the second level appeal a statement regarding whether the claimant has exhausted his or her administrative remedies under the terms of this Plan, as well as any other information required by law.

6. Time Frames for Claim Review Determination

The following time frames apply to any rulings upon a requested claim review:

a) Urgent Care Claims. In the case of a claim involving urgent care, the Fund will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

b) Pre-Service Claims. In the case of a pre-service claim, the Fund will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the Plan of the claimant's request for review of the adverse benefit determination period.

c) Post-Service Claims. In the case of a post-service claim reviewed by the Appeal Committee, the ruling on the claim review will not be made later than the date of the Trustees' meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Trustees' meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination will be rendered not later than the third Trustees' meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan will notify the claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan will notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

d) Disability Claims. In the case of a claim for disability benefits under this Fund reviewed by the Appeal Committee, a ruling on the claim review will be made not later than the date of the Trustee's meeting that immediately follows the Fund's receipt of the claim review, unless the claim review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by not later than the date of the second meeting following the Fund's receipt of the request for review. If the special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination

will be rendered not later than the third Trustee's meeting following the Fund's receipt of the request for review. If such an extension of time for a review is required because of special circumstances, the Fund will notify the claimant, in writing, of the extension, describing the special circumstances and the date by which the benefit determination will be made prior to commencement of the extension period.

7. External Review of Medical Claims

A Participant may seek an independent external review of an adverse benefit determination of a medical claim under the Medical Program or the HRA after exhausting his or her internal appeals, but before filing a lawsuit in court. Unlike the two internal levels of appeal, the external independent review process is voluntary.

The following types of adverse benefit determinations are subject to independent external review:

- an adverse benefit determination that involves medical judgment; and
- a rescission of coverage under the Fund's plan of benefits.

A Participant seeking an independent external review under this process must file a request for an external review with the Fund within four months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

Within five business days following the date of receipt of the external review request, the Fund will complete a preliminary review of the request to determine whether the request is eligible for external review. Within one business day after completion of the preliminary review, the Fund will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration, a division of the U.S. Department of Labor. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Fund will allow the Participant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

If the appeal is eligible for external review and the request is properly filed in a timely fashion, the Participant's appeal will be forwarded to a properly accredited Independent Review Organization ("IRO"). The Fund will ensure that the IRO process is not biased and is truly independent. The external review will be conducted at no cost to the Participant requesting review. The assigned IRO will utilize experts where appropriate to make coverage determinations under the plan or coverage. The IRO will

review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim anew and not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the Participant and to the Fund.

8. Furnishing Documents

In the case of an adverse benefit determination on review, the Plan will provide such access to, and copies of, documents, records and other information as appropriate and required by law.

9. Definitions

The following definitions in this section:

a) A "claim" is any request for a benefit or benefits made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures. Any request for benefits that is not made in accordance with these claims procedures as described in this summary plan description is considered an incorrectly filed claim.

b) A "claimant" is a Member, former Member, Dependent, or beneficiary (designated or contingent) who makes a request for a Plan benefit or benefits in accordance with the Fund's claims procedures as described in this summary plan description.

c) A claim involving "urgent care" means a pre-service claim for medical care or treatment with respect to which the application of the time period that otherwise applies to pre-service claims 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 cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a pre-service claim, the Fund will make a determination as to whether it involves urgent care; in any event, a claim will be treated as an urgent care claim if a physician with knowledge of the claimant's medical condition indicates that the claim involves urgent care.

d) "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon receiving approval in advance of obtaining medical care.

e) "Concurrent care claim" occurs where the Fund approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (i) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (ii) where an extension is requested beyond the initially approved period of time or number of treatments.

f) "Post-service claim" means any claim that is not a pre-service or concurrent care claim.

g) "External review" means an independent review of an adverse benefit determination (including a final internal adverse benefit determination) conducted in accordance with applicable law.

h) "Rescission of coverage" means a retroactive cancellation of coverage of a Fund benefit, other than for failure to pay premiums.

i) "Advance benefit determination" means a decision on a claim that is (1) a denial, reduction, or termination of; or (2) a failure to provide or make payment (in whole or in part) for a benefit under the Fund. A rescission of coverage is treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time).

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