

NOTICE OF APPEAL PROCEDURE

The Fund's Board of Trustees has full and absolute discretion, authority and power to interpret the terms of the Fund's benefit plans, determine all questions of coverage and eligibility and adjudicate benefit claims.

If your benefit claim is denied in whole or in part, you have the right to appeal. If you wish to appeal a benefit denial, you must submit the appeal in writing within 180 days after you receive a denial of benefits. Appeals should be sent to the Appeals Department at the address below.

You may submit with your appeal written comments, documents, or other information in support of your appeal. Inasmuch as the appeal will be decided by the Trustees, the appeal therefore will be decided by a person different from the person who made the initial claim decision and who is not a subordinate of the person who made the initial claim decision. No deference will be accorded to the initial benefit decision.

If a health care professional is consulted in connection with your appeal, the Fund will consult with a health care professional different from the person who was consulted in the initial claim decision and who is not a subordinate of the person who was consulted in the initial claim decision. Upon request, the Plan Administrator will identify any medical expert whose advice was obtained on behalf of the Fund in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

Claims for Disability Benefits and Post-Service Claims for Benefits: You will be notified of the decision on appeal of denial of disability benefits and of post-service claims for healthcare benefits within a reasonable period of time, but no later than five days after the monthly Trustee meeting at which your appeal is decided. If the Fund receives your appeal less than 30 days before the next Trustee meeting, your appeal will be decided at the second Trustee meeting following the date the Fund receives your appeal. If the Fund receives your appeal 30 or more days before the next Trustee meeting, your appeal will be decided at the next Trustee meeting. If special circumstances require additional time to process your appeal, you will be notified in writing of the reason for the extension and the date the claim will be decided, which will be no later than the third Trustee meeting following the date the Fund receives your appeal.

Concurrent Care and Pre-Authorization Claims for Benefits: An appeal of an initial decision to reduce or terminate concurrent care that has not yet been provided will be decided as an appeal of a pre-authorization claim. You will be notified of the decision on appeal of denial of a pre-authorization claim within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days from the date the Fund receives the appeal.

Urgent Claims for Benefits: An urgent claim is any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. You may request an expedited appeal of an urgent claim. The request may be made orally, and the Fund will communicate with you by telephone, facsimile, or similarly rapid communication method. You will be notified of the decision on appeal of an urgent claim as soon as possible, taking into account the medical urgency, but not later than 72 hours after the Fund receives the appeal.

Notice of Appeal Decisions: You will receive notice of the decision on your appeal. If your appeal is denied, the notice of adverse benefit decision will:

- state specific reason(s) for the adverse determination;
- refer to specific plan provision(s) on which the benefit determination is based;
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits;
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request), if the denial is based on a medical necessity or experimental treatment or similar limit ; and
- include a statement regarding your right to commence a legal action under section 502(a) of ERISA.

Legal Actions: You may not bring a lawsuit to recover benefits under any Fund plan unless you have exhausted your appeal rights under the Fund. No action may be brought at all unless it is commenced within two years after a final decision on your appeal. The two-year statute of limitations applies in any forum where you may initiate an action to recover benefits.

APPEAL FORMS ARE AVAILABLE AT NO CHARGE UPON REQUEST FROM THE FUND OFFICE OR MAY BE PRINTED FROM THE FUND'S INTERNET WEBSITE [www.mctwf.org]. THE USE OF THIS FORM IS REQUESTED BUT NOT REQUIRED. IT CONTAINS THE NECESSARY ELEMENTS FOR OUR CONSIDERATION OF YOUR APPEAL. IT IS ALSO HELPFUL IN DISTINGUISHING BETWEEN AN APPEAL, A GENERAL INQUIRY, AND A REQUEST TO CONSIDER ADDITIONAL INFORMATION.

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND
2700 TRUMBULL AVENUE, DETROIT, MICHIGAN 48216-1269
TELEPHONE: (313) 964-2400 FAX: (313) 964-2442 www.mctwf.org