

Claims and Appeals Procedures

The date of these procedures is October 1, 2003. These procedures supersede any prior version.

This section describes the procedures for filing claims for benefits from the Equity-League Health Trust Fund (the "Plan"). It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Authorized Representatives

An authorized representative may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care claim (defined below) without you having to complete the special authorization form.

Definition of a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures including filing a claim (where necessary). The claims procedures vary depending on the specific benefit you are requesting. When the procedures require that you file a claim for benefits offered under this Plan, you must submit a completed claim form. Simple inquiries about the Plan's provisions or about Plan eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim.

The claims procedures vary depending on the Plan of benefits you selected (i.e., depending on whether you are enrolled in an HMO or receive benefits through the Plan's Indemnity Plan). For circumstances where you must file a claim, they must be filed with the appropriate organization listed on pages 6 and 7. You may obtain a claim form from the Fund Office or the Applicable Organization (defined below).

Types of Claims

The claims procedures for HMO benefits, Indemnity Plan benefits (including medical, hospital, and prescription benefits), optical and Supplemental Workers' Compensation benefits will vary depending on whether your claim is for a Pre-Service claim, an Urgent Care claim, a Concurrent Care claim, a Post-Service Claim, a Supplemental Workers' Compensation Benefit claim, or a claim for Plan Eligibility. Read each section carefully to determine which procedure is applicable to your request for benefits. This information about the types of claims is provided as general guidance in accordance with the US Department of Labor regulations. There are other specific claims procedures described in the Equity-League Summary Plan Description or the HMO Member Handbook.

For specific information on the type of claim, or if you have any questions on these procedures, you should contact the Fund Office, Cigna HealthCare (“Cigna”), the applicable HMO or the organization responsible for making the claims determination (the “Applicable Organization”).

For Cigna benefit related concerns that involve a person, a service, the quality of care or contractual benefits, you should start with Member Services. You are encouraged to contact Cigna at the toll-free number, 1-800-251-0669 or write to Cigna at the address below or at the address that appears on the back of your Benefit Identification Card or the explanation of benefits or claim form. Customer Service will do its best to resolve your issues. If Cigna needs more time to review or investigate a complaint of (1) a denial of, or failure to pay, for a referral; or (2) a determination as to whether a benefit is covered under the Plan, Cigna will get back to you on the same day. If Cigna cannot resolve your complaint on the same day, follow the appeal procedures described below.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy will be forwarded to Cigna’s Quality Management staff for review. Cigna will provide written acknowledgement of your concern within 15 days with the appropriate resolution information to follow in a timely manner.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Whether you are covered under Cigna or an HMO, certain services require pre-certification in order to be covered. You will need to follow Cigna’s Pre-Service rules for receiving benefits or the Pre-Service rules of the applicable HMO responsible for making the pre-certification determination. In general, these pre-certifications will determine the medical necessity of a particular service or supply.

If you are enrolled in an HMO, the requirements of any pre-certification program are outlined in the applicable HMO Member Handbook. In order to file a Pre-Service claim, including an Urgent Care claim or Concurrent Care claim, contact the applicable HMO at the number on the back of your ID card.

If you are enrolled in Cigna, the Pre-Service claims program includes Pre-Admission Certification (PAC) and Continued Stay Review (CSR). Under the requirements of the program, there is a \$250 penalty if you fail to pre-certify (1) prior to your scheduled admission date; or (2) in the case of emergency, by the end of the first scheduled work day after the date of admission. In order to file a Pre-Service claim for Indemnity Benefits, call INTRACORP at 1-800-251-0669.

For properly filed Pre-Service Claims, you and/or your health care provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the organization responsible for making the claims determination, and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you improperly file a Pre-Service claim, the organization responsible for making the claims determination will notify you of the proper procedures to be followed in filing a claim as soon as possible but not later than 5 days after receipt of the claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the organization responsible for making the claim determination and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a “claim” under these procedures.

If an extension is needed because the Applicable Organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Applicable Organization then has 15 days to make a decision on a Pre-Service claim and notify you of its determination. If your claim is denied in whole or part, you have the right to appeal the denial of your Pre-Service claim (see “Appeals Procedures” described below).

Urgent Care Claims

An Urgent Care claim is any claim for medical, hospital, prescription or optical care or treatment for which the application of the time periods for making Pre-Service claim determinations:

- (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- (2) 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.

Whether or not your claim is an Urgent Care claim is determined by the Applicable Organization applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care claim within the meaning described above, shall be treated as an Urgent Care claim.

If you improperly file an Urgent Care claim, the organization will notify you and/or the provider of the proper procedures to be followed in filing a claim as soon as possible but not later than 24 hours after receipt of the claim. You (or your representative) must provide the specific information within 48 hours after receiving the notice. Unless the claim is refiled properly, it will not constitute a “claim” under these procedures.

If you are requesting pre-certification of an Urgent Care claim, the time deadlines are different than for Pre-Service claims. The Applicable Organization will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies,

but not later than 72 hours after receipt of the claim by the Applicable Organization. The determination will also be confirmed in writing or electronically within three days.

If an Urgent Care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the organization responsible for making the decision will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the organization receives the specified information or the end of the period given for you to provide this information, whichever is earlier. If your claim is denied in whole or part, you have the right to appeal the denial of your Urgent Care claim (see “Appeals Procedures” described below).

Concurrent Care Claims

A Concurrent Care claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Care claim that involves the termination or reduction of a benefit will be made by the Applicable Organization as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved treatment will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If your claim is denied in whole or part, you have the right to appeal the denial of your Concurrent Care claim (see “Appeals Procedures” described below).

Post-Service Claims

A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained). For notification of a decision on a Post-Service Claim and the Appeal and Review process for such claims, see page 7 below.

Plan Eligibility Claims

A Plan Eligibility claim is treated as a Post-Service claim, and is a claim regarding one’s eligibility to be covered for benefits under the Plan. For a description of the process for submitting a Plan Eligibility claim, or appealing an adverse Plan Eligibility claim determination, see pages 7 and 13.

When and How Post-Service Claims Must Be Filed

Claims should be filed within the time frames listed for each benefit. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

If you receive benefits from an in-network provider under the Indemnity Plan or an HMO provider, you do not have to submit a claim form. Benefits that you receive under the terms of an HMO contract are not considered a claim under these procedures.

For all claims related to benefits other than claims related to an in-network provider under the Indemnity Plan or an HMO provider, claim forms are available from the Fund Office (stop in or call: in New York City: (212) 869-9380, or, outside New York City, (800) 344-5220).

Note: Claims involving Urgent Care may be submitted by telephone to the organization that is responsible for administering the particular benefit you are requesting. (See section below entitled "Where to File Claims" for organization names and telephone numbers or check the back of your ID card.)

If you receive benefits from a hospital or an out-of-network provider and need to submit a claim, you should:

1. Obtain a claim form from the Fund Office and complete the employee's portion of the claim form (including your name and social security number, the patient's name, the patient's date of birth); and
2. Have your Physician either complete the Attending Physician's Statement section of the claim form (including Date of Service, CPT-4 code or hospital services, ICD-9 (the diagnosis code), Billed charge, Number of Units (for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, Billing name and address and, if treatment is due to accident, accident details); or
3. Attach a completed HCFA or UB 92 universal health insurance claim form, or have the provider submit an HIPAA-compliant electronic claims submission.

Attach any other itemized hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Mail any further bills or statements for services covered by the Plan to the Applicable Organization as soon as you receive them.

Where To File Claims

Your claim will be considered to have been filed as soon as it is received at the address below by the organization that is responsible for determining the initial determination of the claim.

HMO Benefits

If you are enrolled in an HMO, you are generally not required to file a claim in order to receive benefits. HMO providers will file claims directly with the HMO. However, if you do need to file a claim, you can do so by contacting the applicable HMO at the address and phone number listed on your ID card and/or in your HMO handbook. This handbook will describe the claims filing deadlines and procedures. You should be aware that benefits that you receive under the terms of an HMO contract are not considered a claim under these procedures.

Set Aside Fund

If you obtain services from an out-of-network physician for an office visit because you are traveling outside your HMO's service area, the Fund will reimburse these charges directly. Submit these claims to the Fund Office at the address on page 7.

Claims need to be filed within 6 months of the date charges are incurred.

Indemnity Plan Benefits

If you are enrolled in the Indemnity Plan (Cigna), the following applies:

You are generally not required to file a claim form in order to be reimbursed for in-network medical providers or for hospital benefits because most claims are submitted directly to Cigna by the medical provider or the hospital.

When you need to submit a claim for out-of network providers or hospital benefits, file these claims with Cigna at:

Connecticut General Life Insurance Company (CIGNA)
CIGNA HealthCare Service Center
P.O. Box 188036
Chattanooga, TN 37422-8036
1-888-336-8258

Medical and hospital claims must be submitted within 12 months of the date charges are incurred. If the claim is not submitted on time, the claim will not be invalidated if it is shown that written proof of loss was given as soon as was reasonably possible.

Prescription Benefits

When you present a prescription to a pharmacy to be filled under the terms of this plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. If you need to file a claim contact Cigna at the address and phone number above.

Claims must be submitted within 12 months of the date charges are incurred. If the claim is not submitted on time, the claim will not be invalidated if it is shown that written proof of loss was given as soon as was reasonably possible.

Optical Benefits

In order to receive optical benefits offered under this Plan, you may visit a Davis Vision provider or you need to file a claim. If you receive services from a non-Davis Vision provider, you may submit a claim to:

Vision Care Processing Unit
P.O. Box 2270
Schenectady, NY 12301

Claims must be submitted within 2 years of the date charges are incurred.

Supplemental Workers' Compensation and Plan Eligibility Claims

Submit claims for Supplemental Workers' Compensation Benefits and claims for Plan Eligibility to the Fund Office at:

Equity-League Health Trust Fund
165 West 46th Street (14th Floor)
New York, NY 10036-2582
In New York City: (212) 869-9380
Outside New York City: (800) 344-5220.

You may obtain a claim form for the Supplemental Workers' Compensation benefit from the Fund Office or any Actors' Equity Office. You must complete the claim form in its entirety. Obtain the name and address of your Employer's Workers' Compensation Insurance Carrier from your Employer. You will also need to attach a statement from your treating physician.

Claims for Supplemental Workers' Compensation must be filed within 3 months from the date of your Workers' Compensation award.

Notification of Claim Determination

Timing of Notification

For notification of a Pre-Service, Urgent Care and Concurrent Care claim determination, see the discussion beginning on page 2 above.

For all Post-Service claims (including Plan Eligibility and optical claims), ordinarily, you will be notified of the decision on your claim within 30 days from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the organization

responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision. For benefits administered by Cigna, this notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Applicable Organization then has 15 days to make a decision on a Post-Service Claim and notify you of the determination. For Cigna claims, the determination period will be suspended on the date Cigna sends a notice of missing information and resume on the date you or your representative responds to the notice.

For Supplemental Workers Compensation claims, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the you are notified prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;

- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- For Urgent Care claims, the notice will describe the expedited review process applicable to Urgent Care claims. For Urgent Care claims, the required determination may be provided orally and followed with written notification.

For Pre-Service, Urgent Care or Concurrent Care claims, you will receive notice of the determination even when the claim is approved.

APPEALS PROCEDURES

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review.

The Fund maintains a mandatory appeal process, which varies depending on the type of claim you are appealing, the nature of the benefit involved (*e.g.* medical or optical) and the organization to which you are making your appeal. The Fund also offers a voluntary level of review for Cigna and HMO benefits after you have exhausted all other mandatory appeals as described in this section.

Overview

In general, for all adverse benefit determinations (i.e., claim denials), you have the right to review documents relevant to your claim. A document, record or other information is relevant if: it was relied upon by the Applicable Organization in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

Your appeal will be reviewed by a person at a higher level of management than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health

care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Review Process and Timing of Notification

HMO Benefits

For HMO benefits, the HMO is responsible for hearing appeals. You should follow the procedures on the back of your ID card or in your member handbook for the address. The appeals procedures and timing of notification will be included on your Explanation of Benefits as well as your Member Handbook. This handbook also explains any external appeals rights you might have.

Indemnity Plan Benefits: Pre-Service, Urgent Care, Concurrent Care and Post Service Appeals

Overview

Any Pre-Service, Urgent Care, Concurrent Care or Post-Service appeal related to medical, hospital or prescription drug claims should be made in writing within 365 days of the receipt of the denial to Cigna at the address below. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal.

You may submit your appeal in writing to:

Cigna HealthCare
PACES Unit
P.O. Box 37963
Charlotte, North Carolina 28237-7963

Appeals may also be made orally by calling Cigna at 1-800-251-0668 Monday through Friday during regular business hours and asking to be connected to the National Appeal Unit. If you call after hours, follow the recorded instructions if you wish to leave a message.

Cigna will acknowledge your appeal in writing within five working days after it has received the appeal. This acknowledgement will include the name, address, and telephone number of the person designated to respond to your appeal and will indicate what information, if any, must be provided.

Cigna maintains a mandatory two level appeal procedure for medical, hospital and prescription drug claims. You may also choose to submit a voluntary third level appeal to the Board of Trustees (discussed below).

In addition, if your appeal for medical or hospital benefits is denied based on absence of medical necessity or the service requested is an experimental or investigational treatment, you may request an External Appeal as described beginning on page 10.

Level One Appeals

You or you authorized representative, with your acknowledgement and consent, must submit your Level One appeal as described above. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For Level One Pre-Service and appropriate Concurrent Care appeals, Cigna will respond in writing with a decision within 15 calendar days. If more information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You are not obligated to grant Cigna an extension or to provide the requested information.

For Level One Post-Service and appropriate Concurrent Care appeals, Cigna will respond in writing with a decision within 30 calendar days after it receives the appeal.

Level Two Appeals

If you are dissatisfied with your Level One appeal decision, you may request a second review. A Level Two appeal must be made in writing to Cigna within 365 days of receipt of the Level One Appeal denial.

For Level Two appeals, Cigna will acknowledge in writing that they have received your request and schedule a Committee review.

Most requests for a second review will be conducted by Cigna's Administrative Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving medical necessity or clinical appropriateness, the Committee will consult with at least one physician reviewer in the same or similar specialty as the care under consideration as determined by Cigna's physician reviewer. You may present your situation to the Committee in person or by conference call.

For Level Two Pre-Service and appropriate Concurrent Care appeals, Cigna will respond in writing with a decision within 15 calendar days after it receives the appeal.

For Level Two Post-Service and appropriate Concurrent Care appeals, Cigna will respond in writing with a decision within 30 calendar days after it receives the appeal.

Expedited Appeals for Urgent Care or Concurrent Care Claims

For either a Level One or Level Two appeal, you may request that the review process be expedited for Urgent Care or Concurrent Care claims denials if the time frames under this process would (1) increase risk to your health, (2) seriously jeopardize your

life, health or ability to regain maximum function, or (3) in the opinion of your physician would cause you severe pain which cannot be managed without the requested services.

You may also request that the appeal of a Level Two review determination be expedited if your appeal involves: (1) a Pre-Service claim in which the health care provider believes an immediate appeal is warranted; or (2) a Concurrent Care claim of: (a) an authorization of an admission or continuing inpatient stay; or (b) continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider.

Cigna's physician reviewer, in consultation with the treating physician will decide if an expedited review is necessary. When a review involving for an Urgent Care or Concurrent Care claim is expedited, Cigna will respond orally with a decision within 48 hours for the Level One appeal and within two working days for a Level Two appeal, after receiving all the necessary information, but no later than 72 hours after receiving the appeal. A written notice of the decision will be transmitted within 72 hours after receiving the appeal. In addition, when a review involving an Urgent Care or Concurrent Care is expedited, Cigna will provide reasonable access to its clinical peer reviewer within one working day after receiving the appeal.

Voluntary Third Level Appeal

Should an adverse benefit determination be made upon review of your claim by Cigna or one of the HMOs, you will have an opportunity to choose a voluntary third level of appeal before the Board of Trustees. This third level of appeal is **completely voluntary**; it is **not** required by the Plan and is only available if you (or your representative) request it.

With regards to claims procedures pertaining to the voluntary appeal:

- The Plan will not assert a failure to exhaust administrative remedies where you or your authorized representative elect to pursue a claim in court rather than through the voluntary level of appeal;
- Where you or your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after you (or your representative) have pursued the appropriate mandatory appeals process required by the Plan, as indicated previously in this chapter;
- Upon your request, the Plan will provide you (or your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including your right to representation, specific information regarding the process for selecting a decision-maker and any circumstances that may affect the impartiality of the decision-maker.

The Plan will not impose fees or costs on you (or your representative), should you or your authorized representative choose to invoke the optional appeals process. Your decision as

to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan.

If you have any questions, please call the Fund Office. To request a third appeal, requests should be made to the Administrative Committee of the Board of Trustees within 180 days of the notification of benefit determination on review at:

Board of Trustees, Administrative Committee
Equity-League Health Trust Fund
165 West 46th Street (14th Floor)
New York, NY 10036-2582
In New York City: (212) 869-9380
Outside New York City: (800) 344-5220.

For Urgent Care and applicable Concurrent Care voluntary appeals, the Administrative Committee, or its designee, will review your appeal and notify you within 72 hours after receipt of your request for review.

For required Pre-Service and applicable Concurrent Care coverage determinations, the Administrative Committee, or its designee, review will be completed and you will be notified of its decision within 15 days after receipt of your request for review.

For Post-Service and applicable Concurrent Care appeals, the Administrative Committee review will be completed no later than the date of the Administrative Committee's meeting that immediately follows your request for review. However, if your request for review is filed within 30 days before such meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of your request for review. If special circumstances require a further extension of time, you will be notified of the extension and the date as of which the benefit determination will be made. You will receive a notice of decision on review within 5 days of the Administrative Committee making the benefit determination.

Optical, Set Aside Fund and Supplemental Worker's Compensation and Eligibility Claims Appeals

The Plan maintains only a one-level appeals process for Optical, Set Aside Fund, Supplemental Workers' Compensation claims and Plan Eligibility claims. Appeals of these claims should be made to the Administrative Committee of the Board of Trustees within 180 days of the initial claims determination.

Board of Trustees, Administrative Committee
Equity-League Health Trust Fund
165 West 46th Street (14th Floor)
New York, NY 10036-2582
In New York City: (212) 869-9380
Outside New York City: (800) 344-5220.

The Administrative Committee of the Board of Trustees will make a determination on your appeal at the next regularly scheduled meeting of the Committee following the Plan's receipt of your request for review of your claim. However, if your request for review is received by the Plan within 30 days preceding the date of such meeting, then the benefit determination on appeal will be made by the Administrative Committee by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, your benefit determination will be rendered not later than the third meeting of the Administrative Committee. If such an extension is required, the Fund Manager shall, not later than the commencement of the extension, provide you with written notice of the extension, describing the special circumstances and the date as of which your benefit determination will be made. You will receive a notice of decision on review within 5 days of the Administrative Committee making the benefit determination.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement describing available voluntary appeal procedures and your right to obtain information about these procedures;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- A statement that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation.

In addition, for every appeal in which coverage is denied on the basis that the service is not medically necessary or is an experimental or investigational treatment, the notice of adverse determination from Cigna must include: (1) a clear statement describing the basis and clinical rationale for the denial; (2) a clear statement that the notice constitutes an adverse

determination; (3) Cigna's contact person and his or her telephone number; (4) the insured's coverage type; (5) the name and full address of Cigna's review agent, if any; (6) the review agent's contact person and his or her telephone number; (7) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service; (8) a statement that you may be eligible for an external appeal and the time frames for requesting an appeal; and (9) a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for you to request an external appeal.

External Appeal Pertaining to Medical and Hospital Benefits

Your right to an external appeal

The External Appeal Program is a voluntary program. You have a right to bring an external appeal for a denial of coverage under certain circumstances. Specifically, if Cigna has denied coverage for medical or hospital benefits on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals. An external appeal may be brought after either a Level One or Level Two appeal. **However, you must file for an external appeal within 45 days of receiving a notice denying your Level One appeal.**

If CIGNA has denied coverage on the basis that the service is not medically necessary or that treatment is experimental or investigational, you may appeal to an external appeal agent if you satisfy the following criteria:

- The service, procedure or treatment must otherwise be a covered expense under this Plan; and
- You must have received an adverse determination through the Plan's internal appeal process (in which Cigna has upheld the denial); OR
- You and Cigna must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life threatening or disabling condition or disease. A life-threatening condition or disease is one which according to the current diagnosis of your attending physician has a high probability of death. A disabling condition or disease is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or

one for which there does not exist a more beneficial standard service or procedure covered by CIGNA or one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered expenses (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your life threatening or disabling condition or disease.

Submitting an External Appeal: For participants in Cigna or New York-based HMOs

You may request an External Appeal application from the New York Insurance Department at 1-800-400-8882 or its website (www.ins.state.ny.us) or the New York Department of Health at its website (www.health.state.us) or Cigna's Member Services department at the toll-free number on your Benefit ID card.

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance.

If you have received an adverse determination on your Level One appeal, which upholds the denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Cigna have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. Cigna will provide an external appeal application with the adverse determination issued through the Level One appeal process or its written waiver of an internal appeal. It will be presumed you received the notification of denial of coverage within 8 days of the date on the notification.

Your physician may file an external appeal by completing and submitting the "New York State External Appeal Application For Health Care Providers To Request An External Appeal Of A Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release the medical records.

You will lose your right to an external appeal if you do not file an application or an external appeal within 45 days from your receipt of the Level One appeal adverse determination, regardless of whether you choose to pursue a Level Two appeal with Cigna. Cigna does not have the authority to grant an extension of this deadline. If you seek a Level Two appeal, you may not have time to request an external appeal.

Submit the completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified external appeal agent. You will have an opportunity to submit additional documentation with your request. If the external appeal agent determines that the information you submit represents a material change from the information on which Cigna or the HMO based its denial, the external appeal agent will share this information with Cigna in order for it to exercise its right to reconsider its decision. If Cigna chooses to exercise this right, it will have three working days to amend or confirm its decision. In the case of an expedited appeal as described in the following section, Cigna does not have the right to reconsider its decision.

You will be charged a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. This fee will be waived if Cigna determines that paying the fee would pose a hardship to you. If the denial of coverage is overturned by the external appeal, the fee shall be refunded to you.

Decisions on External Appeals

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or Cigna or the HMO. If the external appeal agent requests additional information, it will have five additional working days to make its decision. The external appeal agent must notify you in writing of its decision within two working days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request expedited external appeal. In that case, the external appeal agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and Cigna or the HMO by telephone or facsimile of the decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, you will be provided with coverage subject to the other terms and conditions of this document. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, only the costs of services required to provide treatment to you according to the design of the trial will be covered. Cigna will not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing research, or costs which would not be covered under this certificate for nonexperimental or noninvestigational treatments provided in such clinical trial.

The external appeal agent's decision is binding on both you and Cigna. The external appeal agent's decision is admissible in any court proceeding.

Complaints/Appeals to the State of New York

At any time in the appeals process you may contact the Department of Health (for medically related issues) or the Department of Insurance (for billing/contract related Issues) at the following address and telephone number to register your complaint.

New York Department of Health
Metropolitan Regional Area Office
5 Penn Plaza, 2nd Floor
New York, NY 10001
212-268-6306 or 800-206-8125

or

New Rochelle Area Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10810
914-654-7199 or 800-206-8125

or

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
800-342-3736

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which medical services were provided, or, if the claim is for short-term disability benefits, more than three years after the start of the disability.

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