EXHIBIT "B" TO PLAN DOCUMENT

MEDICAL CLAIMS & APPEALS PROCEDURE

1. INTRODUCTION

Under Department of Labor (DOL) regulations, claimants are entitled to a full and fair review of any claim made under the Plan. The procedures described in this document are intended to comply with "effective internal claims and appeals processes" "ACA Rules" enacted under the Patient Protection and Affordable Care Act (ACA) and DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The following procedures apply to any claim for medical benefits (including health, dental, vision and prescription drug). If you believe you are entitled to a benefit under the Teamsters Local 170 Health & Welfare Fund program, you may have to file a claim for such benefit. The procedures for filing a claim may vary with the benefit. If the claim procedure is not explained in the appropriate benefit section, call the Fund Office for an explanation.

APPEALS & GRIEVANCES

The Fund has established an internal and external claims appeal process. You have the right to a full and fair review if you disagree with a decision to deny coverage or payment for services you have received. Also, if you have a complaint regarding the care or service you received from a health care provider who participates in your health care network; or you are denied coverage in this health plan or your coverage is cancelled or discontinued for reasons other than non-payment of your cost for coverage in this plan.

You shall have the right to review your file, and present evidence and testimony as part of the appeals process. Further, the Fund will allow enrollees to receive continued coverage pending the outcome of the appeal process. Claim determinations are made in accordance with Plan Documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

Authorized Representative. You may choose to have another person act on your behalf during the grievance review process. You must designate this person in to the applicable claim reviewer. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. In this case, you do not have to designate the health care provider in writing.) Once an authorized representative is appointed, the care reviewer shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notification regarding decisions, unless the claimant provides specific written direction otherwise.

2. DEFINITIONS

Adverse Benefit Determination: includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims. Failure to make a payment in whole or in part includes any instance where plan pays less that the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding co-payments, deductibles, or other cost sharing requirements.

An adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Rescissions of coverage must also comply with requirements of the regulations restricting rescissions.

Claim: A claim is any request for a plan benefit(s) made in accordance with these claim procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant: You become a claimant when you make a request for a plan benefit(s) in accordance with these claim procedures.

Day: When used in these claim procedures, the term day means calendar day.
Incorrectly-Filed Claim: Any request for benefits that is not made in accordance with these claim procedures is called an incorrectly-filed claim.

Claim Reviewers: Claim reviewers shall include Blue Cross Blue Shield of MA ((1-800-217-7878); Fallon Community Health Plan (1-800-333-2535); Envision Rx Options (1-800-361-4542); Davis Vision (1-800-999-5431).

3. TYPES OF CLAIMS

There are four categories of claims, each with somewhat different claim appeal rules. The Department Of Labor regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined.

Pre-Service Claim: A claim is a pre-service claim if receipt of the benefit, in whole or part is conditioned upon an authorization in advance of obtaining the medical care - unless the claim involves urgent care.

Urgent Care Claim: An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would – in the opinion of a physician with knowledge of the claimant's medical condition – 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 claim reviewer will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

Post-Service Claim: A post-service claim is any claim for a benefit under this Plan that is not pre-service claim or an urgent care claim.

Concurrent Care Claim: A concurrent care decision occurs where the plan authorizes 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: (1) where reconsideration of the authorization results in a reduction or termination of the initially authorized period of time or number of treatments; and (2) where an extension is requested beyond the initially authorized period of time or number of treatments.

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claim procedures, the claim may be re-characterized. If you have any questions regarding the type of claim and /or what claim procedure to follow, contact:

Teamsters Local 170 Health & Welfare Fund
330 Southwest Cutoff Suite 202
Worcester, MA 01604
1-800-447-7730 or (508) 791-3416

4. HOW TO FILE A CLAIM FOR BENEFITS

If you have a problem or concern regarding benefits you may call the applicable claim reviewer. Most problems or concerns can be handled with just one phone call. A customer service

representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible. Please keep a record of the representatives who assist you.

Claims determinations are made in accordance with Plan Documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

When resolving a problem or concern the applicable claim reviewer will consider all aspects of the particular case. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding and expectation of coverage by this health plan. The applicable claim reviewer may use an individual consideration approach when it is judged to be appropriate. The applicable claim reviewer will follow its standard guidelines when it resolves your problem or concern.

If after speaking with the applicable claim reviewer's customer service representative, you still disagree with the decision that is given to you, you may request a review through the applicable claim reviewer's internal formal claim review program. All claims, grievances and/or appeals should include the following:

- Member's Name
- Identification Number
- Description of issue
- All relevant dates
- Names of Physicians, other medical providers, or administrative staff involved with the case
- Details of any attempts to resolve the case
- Names of customer service representatives who assist you
- Comments, documents, records & other information to support your claim

How to Request an Internal Claim Review. To request a formal review from the applicable medical care provider, you or your authorized representative have three options.

- Write or Fax. The preferred option is for you to send your claim/grievance in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616. Blue Cross Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days.

- Write. Member Appeals and Grievances Department, Fallon Health & Life Assurance Company, 10 Chestnut Street, Worcester, MA 01608.

- Write: Envision Pharmaceutical Services, Inc. 2181 East Aurora Road, Suite 201, Twinsburg, Ohio 44087.

- Write: Davis Vision, Inc. Customer Relationship and Information Technology Center, Capital Region Health Park, Suite 301, 177 Troy-Schenectady Road, Latham, New York 12210.

- E-mail. Or, you may send your grievance to the Blue Cross Blue Shield Member Grievance Program internet address grievances@bcbsma.com or Member Relations Department at Fallon Life & Assurance Company grievance@fchp.org.

- Telephone. Or, you may call the Blue Cross Blue Shield Member Grievance Program at 1-800-472-2689; Fallon Community Health Plan Customer Service at 1-800-333-2535, (extension 69959; Envision RX Options Helpdesk 1-(800) 361-4542; Davis Vision
  1-(800) 999-5431.

Once your request is received, the applicable claim reviewer will research the case in detail. They will ask for more information if needed. The claim reviewer will let you know in writing of the decision or the outcome of the review. All appeals must be received by the applicable claim reviewer within 180 days of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

5. TIMEFRAME FOR INITIAL BENEFITS CLAIMS DECISIONS

Urgent Care Claim: The claim reviewer shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims: The claim reviewer shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request: If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least twenty-four (24) hours prior to the end of the initially authorized period of time or number of treatments, the claim shall be decided within no more that twenty-four (24) hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Early Termination: A decision by the claim reviewer to reduce or terminate an initially-authorized course of treatment is an adverse benefit decision that may be appealed by the claimant under these procedures. Notification to the claimant of a decision by the claim reviewer to reduce or terminate an initially-authorized course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Post-Service Claim: The claim reviewer shall decide an initial post-service claim within reasonable time but no later than thirty (30) days after the receipt of the claim.

Timeframe Extensions: Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. If the claim reviewer is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one fifteen (15) day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the claim reviewer's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

Incomplete Claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

Incomplete Urgent Care Claims: If an urgent care claim is incomplete, the claim reviewer shall notify the claimant as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim The notification may be made orally to the claimant, unless the claimant request written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less that forty-eight (48) hours, within which the claim must be completed. The claim reviewer shall decide the claim as soon as possible but not later than forty-eight (48) hours after the receipt of the specified information or the end of the period of time provided to submit the specified information.

Other Incomplete Claims: If a pre-service or post-service claim is incomplete, the claim reviewer may deny the claim or may take an extension of time, as described above. If the claim reviewer takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than forty-five (45) days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided, the medical care provider shall decide the claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

6. NOTIFICATION OF INITIAL BENEFIT DECISION

Once the claim review is completed, the claim reviewer will let you know in writing of the decision or the outcome of the review. This document is often referred to as an EOB or Explanation of Benefits. If the claim reviewer continues to deny coverage for all or part of a healthcare service or supply, the claim reviewer will send an explanation to you. This notice will include: information related to the details of you grievance; the reasons that the claim reviewer has denied the request and applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which the medical care provider has denied the request; any alternative treatment or health care services and supplies that would be covered; the medical care provider's clinical guidelines that apply and were used and any review criteria; and how to request an further review.

In addition, written notification shall be provided to the claimant of the claim reviewer's adverse decision on a claim and shall include the following:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the claim reviewer providers procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;
- 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, disclose either an explanation of the scientific or clinical judgment applying the terms of the claim reviewer to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available of such claims.

Notification of the claim reviewer's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later that one (1) day after the oral notice.

7. HOW TO APPEAL AN ADVERSE BENEFIT DECISION

A claimant (or authorized representative) or the attending physician on behalf of the claimant has the right to request an appeal to an adverse benefit decision and that such review is full and fair. All medical claims are subject to both internal and external appeal processes. An initial appeal must be filed in writing on a Request for Review form within 180 days following the receipt of the notification of an adverse benefit decision, or else you will lose you right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Request for Review form can be requested from and must be submitted to: Benefits Appeals, at the address specified in the initial notification of benefit decision or on the Explanation of Benefits (EOB). Any request for appeal should state why the benefit decision is incorrect. A claimant has the right to submit documents, written comments, or other information in support of an appeal. Once a request for appeal is received, the claimant or the provider may be advised if additional information is needed to finalize the decision. If this additional information (e.g. medical records, etc.) is not received within forth-five (45) days of request for use in making a decision on an appeal, the medical care provider has the right to deny any appeal.

In the light of the shortened timeframes for decisions of urgent care claim, the claimant (or authorized representative) or attending physician may request an expedited single level appeal by telephone, or by any similarly rapid communication method. The appeal should include the identity of the claimant, a specific medical condition or symptom, a specific treatment, service or product for which authorization is requested, and any reasons why the appeal should be processed on a more expedited basis. The appeal determination for an expedited appeal shall be made over the phone within one (1) working day. Expedited appeals which do not resolve a difference of opinion may be submitted through the standard appeal process.

Claims/Grievance Records. You have the right to look at and get copies of the claim file, records and criteria that the applicable claim reviewer has and that are relevant to your appeal. You shall have a reasonable opportunity to present evidence in the course of the internal claims and external appeals process. In addition, you have the right to copies of these records and criteria free of charge, with any new or additional evidence considered, relied on or generated by (or at the direction of) the plan or insurer. Further, the plan or insurer must provide the claimant, free of charge, with a written statement of any new or additional rationale underlying the adverse benefit determination. This information must be provided as soon as possible and with sufficient time to allow the claimant a reasonable opportunity to respond before the date the adverse determination is made. The applicable claims reviewer will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services. In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your grievance review concerns claims reviewer or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by the applicable medical care provider or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, the claims reviewer will review your grievance and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

Pre-service- and Urgent Care: Written notification of the claim reviewer's decision on a pre-service or urgent care claim shall be provided to the claimant whether or not the decision is adverse.

Who Handles the Initial Claim Review. All claims are reviewed by professionals who are knowledgeable about the medical plan and the issues involved in the grievance. The professionals who will review your grievance will be, those who did not participate in any of the applicable claims reviewer's prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When grievance is related to a medical necessity denial, at least one grievance reviewer is an individual who is actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your grievance.

8. RIGHT TO REQUEST EXTERNAL REVIEW

Requesting External Review

A Claimant may request external review of an adverse benefit determination by filing a request for external review within four (4) months after the date of receipt of a notice of an adverse benefit determination. The request for external review must be made in writing to the Teamsters Local 170 Health and Welfare Fund Administrator at 330 Southwest Cutoff, Worcester, Massachusetts 01604 or to the applicable claim reviewer.

Standard External Review

Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- The Claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Claimant was not covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination is based on the fact that the Claimant was not eligible for coverage under the Plan (except where the Claimant relates to a rescission of coverage);
- The Claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- The Claimant has not provided all the information and forms required to process an external review.

The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Claimant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the Claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited External Review

Expedited external review may be requested when:

- An adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- A final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health or ability to regain maximum function; or (b) 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.

The request for an expedited external review must be made in writing to the Teamsters Local 170 Health and Welfare Fund Administrator or the applicable claim reviewer at the address indicated above. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, the Claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

9. EXTERNAL REVIEW BY IRO

Providing Information to IRO

The Teamsters Local 170 Health and Welfare Fund or applicable claims reviewer will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. The Claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

IRO Review

The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- The Claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating health care provider;
- The terms of the Claimant's summary plan description;
- Evidence-based practice guidelines;

- Any applicable clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notification of IRO Decision

The IRO will provide written notice of the final external review decision to the Claimant and the plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision. To the extend the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO.

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within48 hours.

Upon completion of these procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for the Plan benefits must be filed not later than 24 months after completion of the Plan's internal claims procedures (and external review, if applicable).

ERISA Rights Following Review A claimant has the right to sue if Federal Court but only if the claimant has exhausted all claims procedures. You shall be deemed to have exhausted the Fund's administrative procedures if the Fund fails to strictly fulfill all applicable claims and appeals procedural requirements, regardless of whether the compliance defect materially impacted the outcome of the claims appeal decision. In such a circumstance, a claimant may pursue remedies under Section 502 of ERISA, as applicable, which include judicial review of the Plan determination to recover benefits due to him under the terms of the Plan, to enforce his rights under the terms of the Plan, or to clarify his rights to future benefits under the Plan. Additional information may be available from the local U.S. Department of Labor office.