CLAIMS AND APPEALS

VOLUNTARY REVIEW PROCESS

If you disagree with the decision of the Carrier's appeals claim processor, at your option, you may file a voluntary appeal with the Plan.

Your decision to submit an adverse claim determination for review under the voluntary procedure will not have an effect on your rights to any other benefits under the Plan.

You can elect to submit an adverse claim determination for review under the voluntary procedure only after exhaustion of the appeal process described above. To request a voluntary review, submit: Your name, name of plan, reference to the decision, copies of denials, and an explanation of why you are appealing the decision. This information should be submitted to:

The UAW Retiree Medical Benefits Trust
Attention: Voluntary Review
P.O. Box 14309
Detroit, MI 48214-0309

The Carrier's final determination completes the appeal process and you are not required to file a voluntary appeal.

Any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary review is pending. The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a claim determination for review under the voluntary process.

Overview of Claims and Appeals Timeframes for TCN/PPO Plan Option				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No	No	15 days	15 days
Appeal request must be submitted to the Plan within:	180 days	180 days	180 days	180 days

Overview of Claims and Appeals Timeframes for TCN/PPO Plan Option				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	30 days

LEGAL PROCEEDINGS

You may not bring any action in court to recover benefits before you have exhausted all of your remedies under the Plan's claims and appeals procedures. However, you are not required to follow the Voluntary Review Process prior to bringing an action in court. Any lawsuit against the Plan must be commenced within one year from the date of the last decision rendered by the Plan or its Carrier regarding the claim.

AUTHORIZED REPRESENTATIVES

An authorized representative, such as your spouse or other individual, may file a claim for you and represent you in any claim reviews if you are unable to do so yourself. Contact the Carrier for the form needed 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 your having to complete the special authorization form.

ASSIGNMENT OF BENEFITS

Except as expressly authorized by this Plan or as required to comply with a Qualified Medical Child Support Order under the Omnibus Budget Reconciliation Act of 1993, benefits, claims, coverage or other interests in the Plan may not be assigned, transferred, or alienated by a Primary Enrollee. With the approval of the Plan, however, a Carrier may pay a Provider directly for services rendered, in lieu of payment to a Retiree, Surviving Spouse, or Dependent.

IMPROPER OR FALSE CLAIMS

If you (as the claimant) furnish false information on any material subject to the Plan, or to any of its agents or employees, the Plan will deny all or part of your claim and will charge you for any expenses incurred relating to the false information. If benefits have already been paid, based on the false information on a material subject, the Plan will recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or will reduce future benefits for your claims until the Plan has recovered the benefits paid.

The Committee may terminate coverage for any act or omission by a Retiree, Surviving Spouse, or dependent that indicates intent to defraud the plan, such as the intentional and/or repetitive misuse of the Plan's services or the omission or misrepresentation of a material fact on an application for enrollment, claim or other document. Grounds for termination include the submission of any claim and/or statement containing any

materially false information, any information that conceals for the purpose of misleading, and/or any act that could constitute a fraudulent insurance act.