ASO disability claims procedures.

New York Life Group Benefit Solutions as named fiduciary Claim Administrator.

For use only with self-insured ASO disability plans administered by Group Benefit Solutions.

Claims procedures

The Claim Administrator is the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of adverse decisions. The Claim Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Claim Administrator shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Claims for disability benefits (applicable to claims filed on or after April 1, 2018)

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator or the Claim Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Plan Administrator or the Claim Administrator. You must complete your claim according to directions provided by the Plan Administrator or the Claim Administrator. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must file it by submitting it to the Claim Administrator. Properly filed claims will be decided with independence and impartiality.

The Plan has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Plan. The Plan may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30-day periods. If this should happen, the Plan must provide its extension notice in writing before expiration of the curent decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Plan's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Claim Administrator receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Plan may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Plan will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Plan will notify the claimant, in writing, stating what information is needed and why it is needed.

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If the claim is approved, the Plan will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Plan will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse deicsion on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar Plan criteria the Plan relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar Plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. 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 claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of denied disability claims (applicable to claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Claim Administrator. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Plan, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Plan, a full and fair review of the claim appeal will take place.

File the written appeal with the Claim Administrator. The written request for appeal must be received by the Claim Administrator within 180 days from the date the claimant received the denial. If an appeal request is not received within that time, the right to appeal will have been waived. The Plan has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Plan may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Plan must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Plan's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Claim Administrator receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Plan will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Plan for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Plan may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Plan will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Plan will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Plan issues an adverse benefit decision on appeal, if the Plan considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Plan intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Plan will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Plan will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Plan provision(s) on which the decision was based;
3. 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 claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Plan relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

New York Life Insurance Company

51 Madison Avenue
New York, NY 10010

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