APA Pilot Occupational Disability Plan (POD)
Formerly Disability Income Plan (Loss of License)

Appeal Process For Denied Claims

We hope disputes can be resolved if they arise, so that Plan Participants will obtain the benefits to which they are entitled with as little inconvenience and delay as possible. To that end, the Plan provides an appeal procedure, as well as addresses, telephone numbers and other references where additional information and assistance may be obtained.

The following describes the appeal process under this Plan:

(A) If the Plan Participant's claim is wholly or partially denied, the notice of denial must include specific reasons for such denial, reference to Plan terms and conditions on which the denial was based, a description of the Plan's appeal procedures, and the time limits applicable to such procedures. If the claim was denied because necessary information was not available to Harvey Watt, the notice will describe the additional material or information that is required in order for the Plan Participant to perfect his claim and will provide an explanation of why such material or information is necessary. The notice will also include a statement that the Plan Participant has the right to bring a civil action under Section 502(a) of ERISA to seek a judicial decision on his right to the benefit but that no such lawsuit can be filed until the appeal rights provided in this Plan have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part by the BRAB.

(B) If a Protocol was relied upon in making the adverse determination, the Plan Participant is entitled to a copy of the Protocol, or be told that the Protocol was relied upon in making the determination, and that the Plan Participant can receive a copy of the Protocol free of charge, upon written request to APA.

(C) The Plan Participant may request that the BRAB review the denial of all or part of his claim. This request must be in writing and must be received by the BRAB no more than 180 days after the Plan Participant receives notice of Harvey Watt's adverse benefit determination. Any appeal received by the BRAB after this 180-day period will be null and void. The appeal should be addressed to the Benefits Review and Appeals Board, c/o Director of Benefits, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155-2512

(D) As part of the appeal process, the Plan Participant may submit Appeal Materials. The BRAB's review of the appeal must take into account the Appeal Materials, regardless of whether any of the Appeal Materials was submitted or considered in the initial benefit determination; however, only Appeal Materials received by the BRAB prior to the end of the 180-day filing period will be considered. There will be no exception to this rule.

(E) The BRAB will decide the Plan Participant's appeal based on the information provided in accordance with paragraphs (C) and (D) above and the Record from Harvey Watt and/or HealthFirst. No deference will be given to the initial adverse benefit determination, and the decision will be made by the BRAB. The BRAB will not include any individual who made the initial adverse determination or a subordinate of that individual. The BRAB shall have discretion to interpret the Plan and make all determinations on appeals.

(F) If the adverse claim determination was based, in whole or in part, on a medical judgment, including determinations regarding whether treatment, drugs, or other items are experimental, investigational, or not medically necessary or appropriate, the BRAB shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional must not have been involved in the initial adverse claim determination, nor be the subordinate of the professional involved in the initial adverse claim determination. The Plan Participant is entitled to know the identity of any medical or vocational experts whose advice Harvey Watt and/or the BRAB obtained in connection with his claim, regardless of whether his advice was relied upon in making the adverse determination.

(G) The BRAB will advise the Plan Participant of the results of its review within 45 days after it receives the appeal and the timely filed Appeals Materials, unless it determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the request for review. In order for the time to be extended, the Plan Participant must receive notice of the extension within the initial 45-day period. The notice must tell the Plan Participant the nature of the special circumstances and the date by which the BRAB expects to render the decision on review. If the period of time to process the request for review must be extended because of the failure of the Plan Participant or his Physician or medical provider to submit information necessary to a full and fair decision on the appeal, the notice will also state that the period for the BRAB to render the decision will be tolled for up to 90 days from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information. Upon exhaustion of this tolling period, the appeal will be reviewed by the BRAB and a determination made on the Appeal Materials submitted.

(H) When the review of the appeal is completed, the Plan Participant will receive a written decision that will include reference to Plan terms and conditions on which the decision was based. If his appeal has been denied, in whole or in part, the Plan Participant must be told the specific reason(s) for the denial and a reference to specific Plan provision(s) on which the decision is based.

(I) The Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, the Record.

(J) If a Protocol was relied upon in making the adverse determination on appeal, the Plan Participant is entitled to a copy of the Protocol, or to be told that the Protocol

was relied upon in making the determination and that he can receive a copy of the Protocol free of charge, upon request to the APA.

After exhausting the Plan's administrative claims and appeals process as contained in this section, the Plan Participant may bring a civil action under section 502(a) of ERISA for any benefit that is denied in whole or in part. A Plan Participant (or his authorized representative) who fails to complete the Plan's appeal process will not have the right to file suit in court. **NO ACTION IN LAW OR IN EQUITY SHALL BE BROUGHT TO RECOVER BENEFITS UNDER THE PLAN PRIOR TO THE EXHAUSTION OF ALL INTERNAL ADMINISTRATIVE REMEDIES IN ACCORDANCE WITH THE REQUIREMENTS OF THIS PLAN, NOR SHALL ANY ACTION BE BROUGHT AT ALL UNLESS BROUGHT BEFORE THE LATER OF: (1) THREE YEARS AFTER THE DATE A BENEFIT CLAIM IS FILED; OR (2) THREE YEARS AFTER THE DATE ON THE LETTER STATING THE BRAB'S FINAL DECISION ON THE PLAN PARTICIPANT'S BENEFIT APPEAL.**

Nothing in this section shall preclude a Plan Participant's authorized representative from acting on behalf of such Plan Participant in pursuing a benefit claim or appeal to the BRAB of an adverse benefit determination. If the Plan Participant's authorized representative is not a lawyer, the Plan Participant must provide written confirmation that the representative is authorized to act on the Plan Participant's behalf.

Note: The capitalized terms are defined terms in the Plan Document. Please refer to your Plan Document for definitions.

Appeals should be mailed to:

Benefits Review and Appeals Board
c/o Director of Benefits
Allied Pilots Association
14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155-2512