# INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 683 HEALTH AND WELFARE PLAN

## CLAIMS AND APPEALS INFORMATION

This insert describes how to file a claim, when claims are paid, and what to do if a claim is denied. The procedures are different depending on what type of claim you have. There are procedures for medical claims, prescription, dental and vision claims, and death, accidental death, and weekly disability claims. If you are not satisfied with a benefit determination, medical necessity determination, determination of your eligibility to participate in coverage or a decision to rescind your coverage, the International Brotherhood of Electrical Workers Local 683 Health and Welfare Plan (hereinafter the "Plan") offers an appeals process. The process depends on the type of claim you are filing and is set forth in the following pages.

Terms that are capitalized are defined in the Plan's Summary Plan Description and/or Plan Document. Please refer to those documents for the definition of any capitalized terms. As set forth below, the "Claims Administrator" shall be Medical Mutual of Ohio for Medical and Vision Claims; Sav-Rx for Pharmacy Claims; Delta Dental for Dental Claims, and TIC International Corporation for Death, Accidental Death and Weekly Disability Claims.

# CLAIM AND APPEAL PROCEDURE FOR MEDICAL BENEFITS

## A. Types of Medical Claims

The claims process varies depending on your type of medical claim. There are several categories of medical claims for benefits:

1. **Urgent Care Claim.** An Urgent Care Claim is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could:

   1. 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.

   The determination of urgency can be made by:

   3. An individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of medicine; or
   4. Any Physician with a knowledge of the claimant's medical condition who can determine that a claim involves urgent care.

   The Claims Administrator will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Claims Administrator receives the claim. The Claims Administrator may notify you of its determination orally and follow up with written or electronic notification no later than three (3) days after the oral notification.

   If you do not follow the Claim Administrator's procedures or if the Claims Administrator does not receive all of the information necessary to process your claim, the Claims Administrator will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once the Claims Administrator receives the requested information, you will be notified of the benefit determination within 48 hours.

2. **Concurrent Care Claim.** A Concurrent Care Claim is any claim for ongoing treatment, including a plan's approval for a number of treatments. The Plan will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim, if the claim was for Urgent Care and was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve Urgent Care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

   Once the Claims Administrator has approved your Concurrent Care Claim, any reduction or termination by the Claims Administrator of such course of treatment before the end of such period of time or number of treatments shall constitute an adverse benefit determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

3. **Pre-Service Claim.** A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by the Claims Administrator as a condition for payment of a benefit (either in whole or in part).

   The Claims Administrator will notify you of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and date by which it expects to render a decision.

   If an extension is needed because you did not provide the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 15-day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

4. **Post-Service Claim.** A Post-Service Claim is any claim that is not a Pre-Service Claim or a Claim involving Urgent Care.

   The Claims Administrator will notify you of its benefit determination within 30 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and date by which it expects to render a decision.

   If an extension is needed because you did not provide all of the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 30-day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

## B. Who May File a Claim

You may initiate pre-service claims yourself if you are able, or your treating physician may file the claim for you. You are responsible for filing post-service claims yourself, although the Plan may accept billings directly from providers on your behalf if they contain all of necessary information.

You may also appoint an Authorized Representative to act on your behalf. Once appointed, this person may file claims, make inquiries and file appeals on your behalf. To appoint an Authorized Representative, you must provide the Claims Administrator with a written designation. Once you appoint an Authorized Representative in writing, all subsequent communications regarding your claim will be provided to your Authorized Representative.

You may appoint any person as your Authorized Representative except a health care provider. However, a health care provider with knowledge of your medical condition can act as your Authorized Representative for purposes of an Urgent Care Claim (as defined above) without written designation.

## C. When to File a Claim

You must file claims within twelve (12) months of receiving covered services. For this purpose, the claim filing period means one (1) year after:

1. The end of Hospital confinement, if benefits claimed are the result of Hospital confinement; or
2. The date of loss, if benefits are not the result of Hospital confinement.

Your claim must contain the information that the Plan needs to determine your benefits. In order to pay a claim, you must provide proof that you actually incurred a covered claim and the exact amount of your claim. In most cases, a claim form which has been properly completed by you or your Eligible Dependent and your Doctor and an itemized bill(s) are sufficient proof. However, you must honor any reasonable request for further information or for a re-payment agreement or the Plan will not be able to pay your claim.

The Plan will rely on its professional advisors when making a determination as to the validity of your claim. Claims filed after the expiration of the one-year period will be considered only if there was reasonable cause for your failure to timely file the claim.

**D. Where to File a Claim**

Claims should be filed as indicated on your Identification card

**E. What to File in Connection with a Claim**

In order for you to receive benefits, a claim must be filed for you. Many Providers will submit a claim for you. If your Provider does not have a claim form, one can be obtained by contacting the Claims Administrator. If you submit a claim yourself, a claim form can be obtained by contacting the Plan Administrator.

Claims must be submitted to the Claims Administrator within a timely manner, usually twenty (20) days. Therefore, if you or your Provider does not receive a claim form within fifteen (15) days after contacting the Plan Administrator or Claims Administrator, respectively, you may send the Claims Administrator your bill or a written statement from your Provider of the nature and extent of your claim.

Your bill, or statement, must be itemized and include all the information that the Claims Administrator needs to process your claim. This may include the patient's name, identification number, claim number(s) (if applicable) and the dates of service. Your Claims Administrator may require you to complete a claim form after you have submitted your bill or statement.

**F. Filing a Proof of Loss**

Proof of Loss is a claim for payment of health care services which has been submitted to the Claims Administrator for processing with sufficient documentation to determine whether Covered Services have been provided to you. The Claims Administrator must receive a completed claim with the correct information. The Claims Administrator may require Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage.

The Claims Administrator is not legally obligated to reimburse for Covered Services on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within ninety (90) days after you receive Covered Services or as soon as is reasonably possible. No proof can be submitted later than one (1) year after services have been received.

If you fail to follow the proper procedures for filing a claim as described in this booklet, you or your authorized representative, as appropriate, shall be notified of the failure and the proper procedures as soon as possible, but not later than five (5) days following the original receipt of the request. The Claims Administrator may notify you orally unless you provide the Claims Administrator with a written request to be notified in writing. Notification under this section is

only required if:

1. the claim communication is received by the person or department customarily responsible for handling benefit matters; and
2. the claim communication names a specific claimant, a specific medical condition and a specific treatment service or product for which approval is requested.

**G. Method of Claims Delivery**

Pre-service claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

**H. Claim Review**

1. **Consent to Release Medical Information – Denial of Coverage.** You consent to the release of medical information to the Claims Administrator and the Plan when you enroll and/or sign an Enrollment Form and when you present your identification card for covered services. The Claims Administrator has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.
2. **Right to Review Claims.** When a claim is submitted, the Claims Administrator will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. Treatment that is recommended or prescribed by a Provider may not automatically qualify as Covered Service.
3. **Physical Examination.** The Plan may require that you have one or more physical examinations at its expense. These examinations will help to determine what benefits will be covered. These examinations will not affect your status as a Covered Person or your eligibility.

**I. Notice of Claims Denial – Adverse Benefit Determination**

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of an adverse benefit determination will be made in a culturally and linguistically appropriate manner and will include, at minimum, the following:

1. the specific reason(s) for the adverse benefit determination;
2. reference to the specific plan provision(s) on which the adverse benefit determination is based;
3. sufficient information to identify the claim or health care service involved;
4. a description of any additional information necessary to process the claim and an explanation of why the information is necessary;
5. a description of the Claim Administrator's appeal procedures, including the expedited appeal processes, if applicable;
6. notice of the availability of the diagnosis and treatment codes and the corresponding meanings, if applicable;
7. notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;

8. a statement of your right to bring a civil action under ERISA Section 502(a)(3) following an adverse benefit determination on review;
9. if an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
10. if the adverse benefit determination was based on Medical Necessity, Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

*Please note: The processes described above are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the Plan's claims and appeals are also subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth above.*

## J. Miscellaneous Requirements of Covered Individuals

The Plan Administrator may, without consent, release to or obtain any information from another insurance company, organization, or person that it deems necessary to administer this Plan and the Claims Procedures set forth above. If you claim benefits under this Plan, you will be required to provide requested information and sign any authorizations/releases that may be required to implement this provision.

Upon the request of the Trustees, you also may be required to apply for Social Security benefits, Medicare, Medicaid, and/or other applicable program, to continue eligibility under the Plan. At the request of the Board of Trustees, you may be required to sign authorizations/releases enabling the Trustees to obtain information pertaining to your claim for Security Benefits, Medicare, Medicaid and/or another applicable program.

# PROCEDURE FOR REQUESTING EXPEDITED REVIEW AND/OR APPEALING A MEDICAL CLAIM

**A.** Expedited Review Process

A request for an expedited review must be certified by your Provider. The Provider must certify that your condition could, without immediate medical attention, result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or
2. In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your Physician should call the Care Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted the request. With good cause, the time for resolving an expedited review may be extended to five calendar days.

The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

**B.** **Filing an Appeal**

You may file an appeal if you are not satisfied with any of the following:

1. A benefit determination;
2. A Medical Necessity determination;
3. A determination of your eligibility to participate in the Plan or health insurance coverage; or
4. A decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums) you may file an appeal.

To submit an appeal electronically, go to the Claims Administrator's website, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter and send/fax to:

Medical Mutual of Ohio
Member Appeals Unit
MZ: 01-4B-4809
P.O. Box 94580
Cleveland, Ohio 44101-4580
Fax (216) 687-7990

If you are writing a letter of appeal include your full name, patients full name, identification number, claim number (if a claim has been denied), the reason for appeal, date of services, provide/facility name, and any supporting information or medical records.

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process as long as the Claims Administrator has a signed and dated statement from you authorizing the person to act on your behalf. However, in the case of a Claim Involving Urgent Care, a healthcare professional with knowledge of your medical condition may act as your Authorized Representative without a signed and dated statement from you.

## C. First Level Mandatory Internal Appeal

You must file a first level of appeal before any additional action is taken.

The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of adverse benefit determination. The internal appeal process is a full and fair review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to, and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal. The appeals specialist will consider all comments, documents, medical records and other information and materials submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

All determinations of Medical Necessity or medical judgment, whether in whole or in part, will be based on an evaluation and opinion from a health care professional with the appropriate training, skill, and experience in the field of medical judgment in which the claim involves. These health care professionals are independent and impartial. They are not hired, retained, promoted, terminated, or compensated based on their determination of your claim. You may request the identification of the medical professional whose advice was obtained to determine the outcome of an adverse benefit determination, without regard to whether the advice was relied on in making your benefit determination.

If, during the appeal, the Claims Administrator considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of final adverse benefit determination is issued. You will have an opportunity to respond before our time frame for issuing a notice of adverse benefit determination expires. Additionally, if the Claims Administrator decides to issue a final adverse benefit determination based on a new or additional rationale, you will be provided that rationale free of charge before the notice of final adverse benefit determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of final adverse benefit determination expires.

You will receive continued coverage pending the outcome of the appeals process. The Claims Administrator may not reduce or terminate benefits for ongoing treatment without providing you advance notice and an opportunity for advance review.

The following procedures apply to First Level Mandatory Appeals:

1. **Urgent Care Appeal.** The appeal does not need to be submitted in writing. You, your Authorized Representative, or your Physician should call the Care Management telephone number on your identification card. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request to appeal. You may file a request for an expedited external review (described below) at the same time as you request an internal appeal for an urgent care claim.
2. **Pre-Service Claim Appeal.** An appeal of a Pre-Service Claim must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request and must be requested within 180 days of the date you received notice of an adverse benefit determination.

3. **Post-Service Claim Appeal.** As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

### D. Notice of Decision on First Level Mandatory Internal Appeal

All notices of a final adverse benefit determination after an internal mandatory appeal will be culturally and linguistically appropriate and will include specific information pertaining to the determination including:

1. the specific reason(s) for and discussion of the adverse benefit determination;
2. reference to the specific Plan provision(s) on which the adverse benefit determination is based;
3. sufficient information to identify the claim or health care service involved;
4. statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;
5. notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
6. notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
7. disclosure of any internal rule, guideline, protocol or similar criteria that was relied upon in making the adverse benefit determination or the notification of the availability of this information;
8. disclosure of the professional judgment used in making the adverse benefit determination, if it was based on a Medical Necessity, Experimental treatment, or similar exclusion or limit or you will be advised that this explanation will be provided free of charge upon request;
9. a description of applicable appeal procedures; and
10. a statement of your right to bring a civil action under ERISA Section 502(a)(3) following an adverse benefit determination on review.

### E. Second Level Voluntary Review Following Denial of Internal Mandatory Appeal

If your claim is denied at the internal mandatory appeal level, then depending on the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process (described in Section F below) OR the Voluntary Internal Review Process.

The voluntary second level of appeal may be requested at the conclusion of the first level mandatory appeal. The request for the voluntary second level of appeal must be received by the Claims Administrator within 60 days after the receipt of the first appeal decision. The Claims Administrator will complete its review of the voluntary second level appeal within 30 days after receipt of the request.

The health care professionals who review the voluntary second level of appeal will not have made any prior decisions about your claim and will not be a subordinate of the professional who made the determination of your first level appeal.

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without

regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity that are based, in whole or in part, on medical judgment are made by health care professionals who have the appropriate training and experience in the field of medicine involved with your claim.

**F. External Review Process- First Type of Second Level Voluntary Review**

You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process, unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the plan at the time the service was requested or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

The request for External Review must be made within four months after your receipt of the notice of denial from the internal mandatory appeal.

External Review will be conducted by Independent Review Organizations ("IRO"). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision of which IRO to use in not based on the likelihood that the IRO will support a denial of benefits. The IRO will review the claim without being bound by any prior conclusions reached during the internal claim and review process. The Claims Administrator is required by law to provide the IRO with a copy of all records relevant to your claim.

The IRO's determination is binding except to the extent that other remedies may be available under state or federal law to you or the Claims Administrator. If the IRO reverses the adverse benefit determination, the Claims Administrator will provide coverage or payment for the claim.

**The External Review Processes depend on your type of claim:**

Non-Expedited or Non-Urgent Care Claims:

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to the Claims Administrator's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the reasons and rationale for the determination.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to the Claims Administrator's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the reasons and rationale for the determination.

**G. Voluntary Internal Review- Option 2 Second Level Voluntary Review**

If your internal mandatory appeal is denied and your claim does not qualify for an external review, you have the option of a voluntary internal review by the Claims Administrator. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, and other information that were not submitted for the internal mandatory appeal.

The internal review process provides a full and fair review of your claim and will take into account all additional information submitted by you or your Provider.

**Notice of Decision Following Second Level Voluntary Review**

All notices of a final adverse benefit determination after a second level voluntary review will be culturally and linguistically appropriate and will include specific information such as the reasons for the adverse determination and reference the Plan provision(s) on which the decision was based. The notice will include the same detail provided to a First Level Mandatory Appeal denial (see Section D(1)-(10) above).

**H. Final Appeal to Plan Administrator**

If you disagree with the Claims Administrator's decision concerning your first level mandatory appeal or your second level voluntary review, if applicable, you may, at the conclusion of your appeal, file a final appeal with the Plan Administrator. Your final appeal will be decided by the Board of Trustees and must be filed within 180 days after you receive your last appeal decision. The Board of Trustees may consider your final appeal at its next regularly scheduled meeting which immediately follows the receipt of the notice of appeal. However, if your notice was filed within 30 days of the next regularly scheduled meeting, the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal.

After consideration of your final appeal as above, the Board of Trustees will advise you of its decision in writing within five days following the meeting at which the appeal was considered. The decision of the Trustees will be final and binding.

If the claim is payable, a benefit check will be issued to you or made payable to the person or Institution to which you have assigned your benefit payment. Benefits provided or administered by insurance companies or underwriters shall be subject to the review of and decision upon denied claims by such companies or underwriters.

## I. Filing Legal Action

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described in the appeals section of this document. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined herein, you are not satisfied with the result, then you must file any legal action within 180 days after receiving the final review notice under these procedures.

## J. Official Plan Records

You may submit whatever records and evidence you believe are appropriate to support your claim on appeal. However, in determining your eligibility for benefits and, if you are eligible, the amount of your benefits, the Trustees shall rely upon the Official Plan Records. In the event of a discrepancy between the Official Plan Records and a claim asserted by you or your beneficiary, the Trustees shall rely upon the Official Plan Records unless shown to their satisfaction that the additional or other records are valid and that they should rely upon those records. The burden of providing the validity of information that differs from Official Plan Records shall be on you and/or your Eligible Dependent(s).

# CLAIM AND APPEAL PROCEDURE FOR PRESCRIPTION, DENTAL AND VISION BENEFITS

## A. Filing a Claim

You will receive cards for prescription, dental and vision claims. Claims for pharmacy benefits are submitted by the pharmacy when you present your prescription drug card from Sav-Rx. Claims for vision benefits are made by presenting your medical card to the vision provider. The vision claim information is on the back of your medical card. Claims for dental benefits are made by presenting your dental card from Delta Dental. The following process should be used if you disagree with the coverage provided under the Prescription, Vision or Dental Benefit Program.

## B. Filing an Appeal

If you are not satisfied with a benefit determination decision regarding your Prescription Benefit Program, you may file an appeal. All appeals will be given a full and fair review of your claim.

To file an appeal, you must notify the Plan in writing with the following information: full name of the person filing the appeal; patient's full name; identification number; claim number if one has been assigned; reason for the appeal; date of when you were denied your prescription benefit; any supporting information or records you would like to be considered in your appeal. Send or fax the letter to:

TIC International Corporation
I.B.E.W. Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275

## C. First Level Mandatory Appeal

There are two levels of appeal for prescription drug determinations. You must complete both levels of appeal before initiating any legal action in a state or federal court.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of prescription benefits. All requests for appeal may be made in writing, as described in Section B above.

You will be provided with notification of the Plan's benefit determination of your appeal orally as allowed or in writing, as follows:

1. **Urgent Care Claim.** No later than 72 hours after the Plan receives your request for an appeal.
2. **Pre-Service Claim.** No later than 30 days after the Plan receives your request for an appeal.
3. **Post-Service Claim.** No later than 30 days after the Plan receives your request for an appeal.

The first level appeal process entails a review of your appeal by the Pharmacy Benefit Manager. The appeal will take into account all comments, documents, records and other information submitted by you or your Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment will be made in conjunction with health care professional(s) who have the appropriate training and

> The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination of your claim.

experience. The Pharmacy Benefits Manager will consider all presented information and will make a final and binding decision.

Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.

All notices of a denial of benefit will include the following:

1. The specific reason for the denial;
2. Reference to the specific plan provision on which the denial is based; and
3. Your right to bring a civil action under federal law following the denial of a claim upon review.

You may also request the following and it will be provided to you free of charge:

1. Any internal rule, guideline, protocol or similar criteria relied upon in making the benefit determination;
2. If the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the professional judgment; and
3. The identification of the medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

### D. Second Level Mandatory Appeal

If your first level mandatory appeal is denied, you must pursue a second appeal offered by the Plan. All requests for appeal may be made in writing to the Third-Party Administrator at the address listed in Section B above. You may submit additional written comments and other information relating to the claim being appealed.

The second level appeal shall be requested at the conclusion of the first level of appeal. The request for the second level appeal must be received by the Plan within sixty (60) days from your receipt of the first appeal decision. The Board of Trustees will complete its review of the mandatory second level appeal at the next regularly scheduled Board of Trustees meeting provided your appeal is received at least 20 days prior to the scheduled date of the meeting. You may request to be present at the Board of Trustees' meeting to present your appeal.

The second level appeal provides a full and fair review of the claim. There will be a review of your appeal by the Board of Trustees and, if determined to be needed, other licensed health care professional(s). The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity that are based in whole or in part on a medical judgment will be made in conjunction with health care professionals. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim. The decision of the Board of Trustees will be made, in the sole discretion of the Trustees, based upon the medical information presented to it, and such decision will be final and binding.

In order to process your appeal, you agree that any person claiming benefits will furnish the Plan with any information the Plan needs and that the Plan may, without the consent of or notice to any person, release to or obtain necessary information from any person.

**E. Denial of Second Level Appeal**

If you appeal is denied, you may provide the Plan Administrator (address provided above) a written request, within 60 days of when you receive your notice of denial, for a final decision in writing, which shall state the specific reasons for the decision and the relevant Plan provisions on which the denial decision was based.

**F. Right to Initiate Legal Action Upon Denial of Second Level Appeal**

If the Trustees deny your second level appeal and you are dissatisfied with the Trustees' decision, you may initiate legal action by filing suit in state or federal court. No action, at law or in equity, may be brought against the Plan to recover benefits more than 180 days after you receive notice of the denial of your appeal.

**G. Facility of Payment**

If a payment that the Plan should have made under the Plan's prescription drug program is made under any other health care plan, then the Plan has the right to make payment to whoever paid under the other health care plan. The Plan will determine the necessary amount to be paid under this provision. Amounts so paid are benefits under this Plan, and the Plan is discharged from liability to the extent of such amounts paid for covered services.

**H. Right of Recovery**

If the Plan pays more for covered services than it should have paid under the Plan's prescription drug program, the Plan has the right to recover, on behalf of the Plan, the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

# CLAIM AND APPEAL PROCEDURE FOR DEATH, ACCIDENTAL DEATH AND WEEKLY DISABILITY CLAIMS

## A. Claim Procedure for Death, Accidental Death and Weekly Disability Claims

In order to file a claim for a Death, Accidental Death or Weekly Disability Benefit, you must first obtain a claim application form. Claim forms are available from the Third-Party Administrator at the following address and phone number:

TIC International Corporation
I.B.E.W. Local No. 683 Health and Welfare Plan
6525 Centurion Drive
Lansing, Michigan 48917-9275

Any claim for payment of Death, Accidental Death or Weekly Disability Benefit must be filed with the Third-Party Administrator within one year after the date on which the claim was incurred. Claims filed after the expiration of these time periods will only be considered if there was reasonable cause for failure to timely file the claim, as determined by the Trustees in their sole discretion. If proof of a claim cannot be furnished to the Third-Party Administrator within the required time period, it will not be denied or reduced if proof is furnished as soon as reasonably possible. Unless you are legally incapacitated, failure to timely file the claim within one year after the date on which the premium was due shall invalidate or reduce benefits, as decided within the sole discretion of the Trustees, and the Trustees' decision shall be final and binding.

A decision as to the validity of the claim will be made as promptly as possible after the claim is received, with necessary documentation. If a delay occurs, you will be notified of the reasons for the delay, as well as the anticipated length of the delay, in writing. If further information or other material is required, you will also be informed. You must honor any reasonable request for further information or for a re payment agreement or you will not be able to receive payment on your claim.

## B. Appeal Procedure for Denial of Death, Accidental Death and Weekly Disability Claims

In the event your claim for Death, Accidental Death or Weekly Disability Benefits is denied, you will be notified in writing by the Third-Party Administrator of the reasons why your claim was denied. Notification of a decision shall within a reasonable time after your claim is submitted but no more than ninety (90) days of the receipt of your approved claim form by the Third-Party Administrator for Death and Accidental Death Claims and no more than forty-five (45) days of the receipt of your approved claim form by the Third-Party Administrator for Weekly Disability Claims. If the Third-Party Administrator determines that more time is needed to process the claim due to matters beyond his/her control, the Third-Party Administrator will notify you of a thirty (30) day extension. If a second extension is necessary due to matters beyond his/her control, the Third-Party Administrator will notify you of a final thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to Death, Accidental Death and/or Weekly Disability Benefits is based, the unresolved issues preventing a decision and any additional information that is needed to resolve the claim.

All claims and appeals for Death, Accidental Death and Weekly Disability Benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation,

termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

In the event of non approval in whole or in part of your Death, Accidental Death or Weekly Disability Benefit claim, notice to you shall provide you all of the following information in the written decision:

1. the specific reasons for rejecting the application; and
2. the specific provisions of the Plan or rules and regulations on which the determination is based; and
3. a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and
4. an explanation of the Appeals Procedure; and
5. a statement regarding your right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal; and
6. the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards or similar criteria of the plan do not exist; and
7. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to your claim for benefits
8. In addition, with respect to Weekly Disability Benefit claims, in the event the determination disagrees with the views of (1) a health care professional treating you; (2) vocational professionals who have evaluated you; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your claim; or (4) a disability determination regarding you made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a medical necessity, experimental treatment or similar exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

The decision shall be final and binding upon you unless that decision is appealed as hereinafter set forth below.

In the event your claim for Death, Accidental Death, or Weekly Disability Benefits is denied, you may, by written notice received by the Third-Party Administrator within one hundred and eighty (180) days of your receipt of the notice denying your claim for Death, Accidental Death or Weekly Disability Benefits, appeal the decision. The written notice should state your name, address and the reasons why you are appealing from the decision of the Third-Party Administrator, giving the date of the decision you are appealing.

The review of your appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject of the appeal nor a subordinate of such individual. If the appeal of a decision based in whole or in part on medical judgment, the appropriate named fiduciary 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 shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny an appeal, you will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan, or other person making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the plan administrator shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date.

The Trustees shall consider your appeal no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal. If such extension is required, you will be provided with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made prior to commencement of the extension.

After consideration of the appeal as above, the Board of Trustees shall advise you of its decision in writing within five (5) days after the benefit determination is made. If the determination is averse to you, the written decision shall state all of the following information:

1. the specific reasons for rejecting the appeal; and
2. the specific provisions of the Plan or on which the determination is based; and
3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. a statement of your right to bring an action under Section 502(a) of ERISA; and
5. the applicable contractual limitations period that applies to your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim; and
6. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
7. for Weekly Disability Claims, a discussion of the decision including an explanation for disagreeing with or not following any of the following:
    a. the views of health care professionals treating the claimant; or
    b. the views of vocational professionals who evaluated the claimant; or
    c. the views of medical or vocational experts whose advice was obtained on behalf of

the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or

d. a disability determination made by the Social Security Administration.

If the adverse benefit determination is based on medical necessity, experimental treatment or a similar exclusion or limit, you will be provided either with an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

All notices to you will be made in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any "applicable non-English language" and providing assistance with filing claims and appeals in "any applicable non-English language." In addition, the Plan will provide, upon request, a notice in any "applicable non-English language" and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. "Applicable non-English languages" include, with respect to an address in any United States county to which a notice is sent, a non-English language in which ten percent or more of the population residing in the county is literate only in that language.