

# *Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund*

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## **CLAIMS AND APPEALS PROCEDURES FOR THE OHIO CONFERENCE OF PLASTERERS AND CEMENT MASONS HEALTH AND WELFARE PLAN**

The procedures which you need to follow in order to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. You will be provided with any future changes to the procedures in a separate document. Please make sure you review all correspondence about your Fund and keep these additional procedures with your booklet issued December 1, 2000.

### **HOW TO FILE CLAIMS FOR MEDICAL BENEFITS**

Effective for claims filed under Medical Mutual Services, the new Preferred Provider Network, you need to follow the following procedures in order to obtain payment for your medical claims. When you receive health care services:

- Show your identification card to the service provider
- Ask the provider to file a claim for you

If your provider of the medical service is a Participating Provider in the Medical Mutual Network, he/ she will submit all necessary claim information to Medical Mutual on your behalf. Medical Mutual will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Medical Mutual Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor, medical facility, or other provider
- Obtain a claim form from the Fund's Administrative Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address, if different
- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by Medical Mutual. The Fund's Administrative Office will process your claim within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or part with an explanation of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

## **HOW TO FILE CLAIMS FOR PRESCRIPTION BENEFITS UNDER THE NPA PROGRAM**

You will receive a personalized National Prescription Administrators (NPA) Prescription Benefits Identification Card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating NPA pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits. If you do not receive your prescription at the NPA retail pharmacy due to a denial of coverage, you need to contact the Administrative Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating NPA pharmacy, do not use your NPA Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a NPA Direct Reimbursement form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to NPA's address on the form. Reimbursement will be made directly to you by NPA on the same basis as benefits would have been paid to a participating NPA pharmacy.

If you are not eligible for benefits at the time you contact the NPA pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

### **HOW TO FILE A CLAIMS FOR DENTAL AND VISION BENEFITS**

When you receive dental or vision services:

- Show your identification card to the provider of service
- Ask the provider to file a claim for you

If the provider of service files a claim for you, he/she will then submit all necessary claim information to the Fund's Administrative Office and will receive reimbursement directly.

In some cases, however, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the dentist or vision facility
- Send the bill to the address on the identification card

An itemized bill generally includes all of the following:

- Patient's name and address
- Date of Service
- Type of Service and diagnosis, if applicable
- Itemized charges
- Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care vendor unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by the Fund's Administrative Office. The Fund's Administrative Office will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your

claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund's Administrative Office that the claim is denied with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure set forth below.

### **HOW TO FILE CLAIMS FOR SICKNESS AND ACCIDENT BENEFITS**

*Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims.* Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

The Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

### **HOW TO FILE CLAIMS FOR DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

*Claims should be submitted as soon as possible; do not delay in filing any claims.* Claims for Death, Accidental Death and Accidental Dismemberment Claims will be provided through the Fund's Administrative Office. You or your beneficiary must contact the Fund's Administrative Office in order to obtain a claim form. You or your beneficiary must submit the completed claim form with all required documentation to the Fund's Administrative Office.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within ninety (90) days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial ninety (90) day period.

When the claim for life insurance benefits falls within the policy exclusions, you or your beneficiary will be notified by the Fund's Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/ she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse benefit determination;

- The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;
- A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;
- A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and
- A description of the Fund's Appeals Procedure provided below.

**PROOF OF CLAIMS**

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically. **All claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

**PHYSICAL EXAMINATION**

The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

**REVIEW PROCEDURE FOR MEDICAL, DENTAL, VISION, PRESCRIPTION, LOSS OF TIME, DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT CLAIMS**

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, dental, vision, sickness, death or accidental death and dismemberment benefits in whole or part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure.

### **First Level Review**

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Administrative Manager  
Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan  
33 Fitch Blvd.  
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Administrative Manager shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Administrative Manager will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

The decision of the Administrative Manager is final and binding unless it is appealed to the Benefits Committee under the procedures provided below for Second Level Reviews.

### **Second Level Review**

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee  
Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan  
33 Fitch Blvd.  
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Benefits Committee within thirty (30) days of the date the request for a Second Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;

- A notice of your right to file a voluntary appeal to the full Board of Trustees as provided below; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding.

**VOLUNTARY APPEAL TO THE BOARD OF TRUSTEES**

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to filing a lawsuit, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee.

The Appeal should be addressed as follows:

Board of Trustees  
Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan  
33 Fitch Blvd.  
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next regularly scheduled meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

- The Fund will not assert a failure to exhaust administrative remedies;
- The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
- The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
- You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
  - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;

- A statement that you have the right to have a personal representative with regard to your claim;
- A notice of any circumstances which may impair the impartiality of the Board of Trustees;
- The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

In the event the denial is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).