

APPLYING/CLAIMING YOUR SUPPLEMENTAL HEALTH BENEFITS

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The procedure for claiming your General Medical Reimbursement, Dental, Vision, Prescription Drug, Hearing Aid, Mental Health and Podiatry Benefits are set forth under the heading “Getting Your Benefit” in each section below describing each type of benefit. The procedures for the determination of claims and appeals for all supplemental health benefits are described below in the “Claims and Appeals” section.

Please pay special attention to the time limits for filing your claims.

IN GENERAL, ALL SUPPLEMENTAL HEALTH BENEFITS MUST BE CLAIMED NO LATER THAN NINETY (90) DAYS AFTER THE SERVICE IS RECEIVED. CLAIMS FILED AFTER THAT DATE WILL BE DENIED.

If you require claim forms, visit or call the Fund Office at:

CWA Local 1180 Security Benefits Fund
6 Harrison Street
New York, NY 10013-2898
1-212-966-5353
1-888-966-5353 (out-of-area)

You can also download Claim Forms by logging into your member portal at: www.cwa1180.org

When Benefits May Be Withheld or Denied

Recovery of Overpayments or Mistaken Payments

If you received benefits from the Fund to which you are not entitled, on your behalf or on behalf of your spouse or children, you are required to make restitution of the overpayment or mistaken payment promptly.

If you fail to do so, the Fund will offset any future benefit payments by the amount of the mistaken payment until full restitution of the amount of the mistaken payment or overpayment is made.

Right To Audit and Verify Claims

Before or after paying any benefits, the Fund reserves the right to audit and verify any claims that are submitted to the Fund.

CLAIMS AND APPEALS

Request for Review of Denial of Claim

If your claim for supplemental health benefits is denied and you disagree with the decision, you may request a review of your claim.

The procedures for claiming each supplemental benefit are set forth under the heading “Getting Your Benefit” in each section below describing each type of benefit. Except where the service provider or the organization administering the benefit submits the claim, all initial claims for benefits by a Member or Beneficiary (hereinafter for purposes of the Section the “Claimant”) under the Plan must be in writing and sent to the Fund Office, to the attention of the Trustees.

Determination of Claims

The procedures for determination of claims differ depending on whether it is a post-service claim, a pre-service claim, an urgent care claim, or a concurrent care claim.

Post-Service Claims

A **post-service claim** is a claim for benefits that are not conditioned on advance approval.

Typically, a post-service claim is a claim made after you have received the medical care to which the claim relates. In the case of pharmacy and some dental benefits, the organization administering the benefit (Capital Rx, Daniel H. Cook Associates, or Dentcare/Health Plex, for example) and/or the Fund Office will make the decision on the claim and notify you thereof within 30 days. On all other post-service claims, the Fund Office will make a decision on the claim and notify you thereof within 30 days. If the Fund Office determines that matters beyond the Fund’s control require an extension of time for processing the claim, the 30-day period may be extended once for up to 15 days, and the Fund Office will notify you in writing prior to the termination of the initial 30-day period. Such notice will include an explanation of the

circumstances requiring an extension of time, and the date by which the Fund expects to render its decision. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed, and you will be have 45 days from receipt of the notice to provide the specified information. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Pre-Service Claims

A **pre-service claim** is a claim for a benefit that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care. In the case of pharmacy and some dental benefits, the organization administering the benefit and/or the Fund Office will make the decision on the claim and notify you thereof within 15 days. On all other pre-service claims, the Fund Office will make a decision on the claim and notify you thereof within 15 days. If the Fund Office determines that matters beyond the Fund's control require an extension of time for processing the claim, the 15-day period may be extended once for up to an additional 15 days, and the Fund Office will notify you in writing prior to the termination of the initial 15-day period. Such notice will include an explanation of the circumstances requiring an extension of time, and the date by which the Fund expects to render its decision. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed, and you will be have 45 days from receipt of the notice to provide the specified information. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Urgent Care Claims

An **urgent care claim** is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- (A) could seriously jeopardize your life, health, or ability to regain maximum function, or,
- (B) 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.

In the case of pharmacy and some dental benefits, the organization administering the benefit and/or the Fund Office will make the decision on the claim and notify you thereof within 72 hours, unless you fail to provide sufficient information to determine whether, and to what extent, benefits are covered or payable under the Plan. On all other urgent care claims, the Fund Office will make a decision and notify you thereof within 72 hours, unless you fail to provide sufficient

information to determine whether, and to what extent, benefits are covered or payable under the Plan. In the event of a failure to provide sufficient information as described above, the Fund Office shall notify you within 24 hours of receipt of the claim of the specific information necessary to complete the claim. You will have not less than 48 hours to provide the specified information. The Fund Office will notify you of its decision on the claim within 48 hours of the earlier of (a) its receipt of the specified information or (b) the deadline it gave you for providing the specified information.

Concurrent Care Claims

A **concurrent care claim** is claim concerning an ongoing course of treatment to be provided over a period of time or number of treatments, where the Fund has already approved that course of treatment. If, after such approval, the Fund decides to reduce or terminate the course of treatment (other through plan amendment or termination), the Fund Office will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on appeal before the reduction or termination takes effect. In the case of dental and pharmacy benefits, the vendor and/or the Fund Office will make the decision on the claim. If you request to extend the course of treatment and the request is an urgent care claim, the Fund Office will notify you of its decision on the request within 24 hours, provided that the request is made at least 24 hours prior to expiration of the prescribed period of time or number of treatments.

If Your Claim Is Denied

You will be provided with written notice if your claim is denied (whether denied in whole or in part). This notice will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the determination
- a description of the Plan's standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits
- a statement of your right to bring a civil action following an adverse benefit determination on appeal.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, you will receive either a copy of such rule or a statement that it will be provided to you on request free of charge.

If the denied claim was an urgent care claim, you will be provided with a description of the expedited review process applicable to such claims. The notice of denial of an urgent care claim may be provided orally within the applicable time frame, followed by written notice within 3 days.

BOARD APPEAL PROCEDURES

These procedures apply to all appeals to the Board of Trustees concerning supplemental health benefits, but they apply in different ways depending on the type of benefit.

For dental benefits, as explained below, your initial appeal must be submitted to the vendor through which the benefits are provided (such as Dentcare or EmblemHealth, for example), and if that appeal is denied, you have the option of submitting an additional, voluntary appeal to the Board of Trustees pursuant to the procedures set forth in this section and subject to the Voluntary Appeal Provisions described below.

For all other supplemental health benefits, the procedures described in this section apply to your initial appeal of a benefit claim, which must be submitted to the Board of Trustees.

The Board appeal process works as follows:

- You must submit your appeal of an adverse benefit determination within 180 days of receiving notice that your claim was denied. You may submit written comments, documents, and other information relating to the claim relating to the claim within the 180-day period following the date of the decision that you are appealing.
- You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office in making its decision; if it was submitted, considered or generated in connection with your claim (regardless of whether it was relied upon in deciding to deny the claim); or if it demonstrates compliance with the Fund Office's administrative processes for ensuring consistent decision making; or if it constitutes a statement of Plan policy regarding the denied treatment option or benefit for your diagnosis (regardless of whether it was relied upon in deciding to deny the claim).
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office on your claim, without regard to whether their advice was relied upon in deciding your claim.
- Your claim will be reviewed by the Board of Trustees, which is not subordinate to (and shall not afford any deference to) the person who originally made the adverse benefit determination. The Board's decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

- You will also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on appeal is denied based on a new or additional rationale, you will receive a statement of the rationale, free of charge.
- For urgent care claims, you may provide notice of your appeal orally and all necessary information shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Decision on Appeal

Timing

For post-service claims, a decision on an appeal will ordinarily be made at the next regularly scheduled quarterly meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

For pre-service claims, the Board shall decide on the appeal and provide notice of its decision to you within 30 days after receipt of your appeal.

For urgent care claims, the Board shall decide on the appeal and provide notice of its decision to you within 72 hours after receipt of your appeal.

For concurrent care claims, an appeal concerning reduction or termination of an approved course of treatment shall be decided, and notice of the decision shall be provided, before the reduction or termination takes effect. Appeals of other concurrent care claim denials shall be governed by the procedures above, depending on whether the claim is post-service, pre-service, or urgent.

Form and Contents of Notice

The decision on any appeal of a claim will be given to you in writing. The notice of a denial of an appeal will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the determination

- a description of the Plan’s standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- a statement of your right to bring a civil action following an appeal
- the statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

If an internal rule, guideline or protocol was relied upon by the Plan in denying the appeal, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Dental Benefit Appeals

If you wish to appeal a dental benefit determination, you must submit the appeal directly to the vendor through which the benefits are provided, pursuant to the following procedures:

If you wish to appeal a benefit determination by **Dentcare**, appeals must be made within 180 calendar days after you receive notice of the adverse determination. If you believe an expedited appeal is warranted due to a problem that seriously affects your health, or any other urgent matter, you may request an expedited appeal by calling Dentcare at 1-800-468-0600. If you wish to appeal the determination with a standard appeal, you may request a standard appeal in person, in writing, or by telephone at 1-800-468-0600 (TTY/TDD: 1-800-662-1220). Written appeals should be sent to:

Dentcare Delivery Systems, Inc.
Attn: Appeals Unit
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553

Expedited appeals will be determined within 72 hours from receipt of the appeal or two business days of receipt of the necessary information to conduct an appeal. Dentcare will acknowledge your standard appeal request within 15 calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling your appeal, and indicate what information, if any, must be provided. If your appeal related to a preauthorization request, Dentcare will decide the appeal within 30 days of receipt of the appeal request. If your appeal related to a retrospective claim, Dentcare will decide the appeal within 60 days of receipt of the appeal request. Dentcare’s failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal will be deemed a reversal of the initial adverse determination.

If you wish to appeal a benefit determination on dental benefits administered by **Daniel H. Cook Associates**, appeals must be made within 180 calendar days after you receive notice of the adverse determination. You must fully set forth the basis of your appeal and address your appeal to:

CWA Local 1180 Active
c/o Daniel H. Cook Dental Assoc., Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

If you wish to appeal a decision by **EmblemHealth**, you may appeal it by writing to:

GHI, Complaints and Audits Unit
P.O. Box 2838
New York, NY 10116-2838

You may also call GHI Customer Service at 1-800-624-2414 or visit their offices at 55 Water Street, New York, NY 10041. You must submit your grievance request within 180 days of the notice you are appealing. Emblem will acknowledge your grievance within 15 calendar days. They will respond within 30 calendar days of receiving your grievance.

If you wish to appeal a benefit denial by **Empire BlueCross BlueShield**, you can file a grievance/appeal to Empire by phone at (877) 606-3338 or in writing. You have up to 180 calendar days from when you received the decision you are asking Empire to review to file the grievance. Empire will mail an acknowledgment letter within 15 business days. Empire will notify you of its determination on expedited/urgent grievances within 72 hours of receipt of your grievance. Empire will notify you of its determination on pre-service grievances (a request for a service or treatment that has not yet been provided) within 30 calendar days of receipt of your grievance. Empire will notify you of its determination on post-service grievances (a claim for a service or a treatment that has already been provided) within 60 calendar days of receipt of your grievance.

If your appeal is denied by Dentcare, Daniel H. Cook Associates, EmblemHealth or Empire Blue Cross BlueShield, you **may** submit an appeal of the denial (also known as an “adverse benefit determination”) in writing to the Board of Trustees within 180 days of the date of the decision.

This is a voluntary level of appeal, subject to the following Voluntary Appeal Provisions:

- Any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

- The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to this voluntary level of appeal;
- You may elect to submit a benefit dispute to such voluntary level of appeal only after exhausting the appeal procedures provided by Dentcare, Daniel H. Cook Associates, EmblemHealth or Empire BlueCross BlueShield;
- The Plan will provide upon request, sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and
- No fees or costs are imposed on you as part of the voluntary level of appeal.

If you choose to submit the voluntary appeal, your appeal will be reviewed and decided by the Board pursuant to the procedures described in the “Board Appeal Procedures” section above.
