SECTION SIXTEEN: Filing Your Claims and Appeals

For out-of-network *medical* care, you must file your claims with UnitedHealthcare within one year of receiving a covered service. Your provider may file a claim, but if they do not, it is your responsibility to file a claim. If you are not sure, ask your provider or contact UnitedHealthcare. To file a claim, send an itemized bill to UnitedHealthcare, Attention: P.O. Box 740800, Atlanta, GA 30374-0800. Failure to provide information may delay any reimbursement that may be due to you. Be sure to include the following:

- Your name and address
- The patient's name, age and relationship to the participant;
- Your UnitedHealthcare identification number;
- The name, address, telephone number, and tax identification number, of the provider who performed the service;
- A diagnosis from the Physician
- An itemized bill from the provider that includes
    - The date and description of the service; and
    - The charge for that service.
    - The Current Procedural Terminology (CPT) codes
    - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

I. Payment for Out-of-Network Care

After UnitedHealthcare has processed your claim, you will receive payment for benefits that the Plan allows. It is your responsibility to pay the out-of-network provider the charges you incurred, including any difference between what you were billed and what the plan paid.

UnitedHealthcare will pay benefits to your provider only if the following conditions are met:

- The provider notifies UnitedHealthcare that you have provided a signed authorization to assign benefits directly to the provider.

OR

- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will not pay your benefits to a third party even if your provider has assigned benefits to that third party.

A. Dental Claims

- **In-Network**

The Teamsters 251 Health Services and Insurance Plan provides dental benefits to Plan participants and has selected Delta Dental to administer dental claims under this Plan. Accordingly, Delta Dental processes your dental claims. Generally, you are not required to file your own claim form for in-network care.

- **Out-of-Network**

If you receive dental care from an out-of-network provider, you may have to pay the entire cost at the time you receive services, and you may have to file your own claim form to receive reimbursement. Ask the dentist to complete a standard American Dental Association claim form and mail it to:

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517

You will have to pay any amount that an out-of-network provider charges above the allowance amount. In other words, the Plan will only reimburse you for the amount that a Delta Dental provider would have charged.

Filing Your Claims

Dental claims must be filed within one year of the date of service in order to be considered for payment.

B. Vision

There are no claim forms for you to fill out when you receive vision care services from a Davis Vision provider. The provider will file your claims for you.

C. Hearing

For benefits obtained through Sargent, obtain a claim form from the Fund Office. Complete the form and bring the claim form with you to your appointment. Make an appointment by calling (401) 886-6600. For benefits obtained through UnitedHealthcare, follow the medical claims procedures.

D. Prescription Drugs: See *Section Five RX*

E. Weekly Accident and Sickness Claims: See *Section Twelve*

F. Claims for Death, Accidental Death, and Personal Loss Benefits

The benefit will be paid in full in accordance with the terms of the insurance certificate to the last named beneficiary on file at the Fund Office **upon receipt of the Certified Death**

Certificate. In the event of an accidental death or personal loss, the Fund Office should be contacted for instructions on filing a claim for benefits.

Aetna must be given written proof of the loss for which claims is made under the coverage. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of loss or as soon as reasonably possible. Aetna, at its own expense, has the right to examine the person whose loss is the basis of claim. See *Section Sixteen* for details on filing your claims.

II. Timeline for Denial and Appeal of Your Health Care Claims

There are four basic types of health care claims. Each type of claim has a unique timeframe. All final decisions on self-insured benefits may be appealed to the Trustees.

A. Pre-Service

A pre-service claim is a claim for benefits where prior authorization is required. The Plan will not deny benefits for these procedures or services if:

1. It is not possible for you to obtain prior authorization; or
2. The prior authorization process would jeopardize your life or health.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing (Business Days)**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	**15 days**
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing (Business Days)**
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

B. Urgent Care

An urgent care claim is a type of a pre-service care claim. You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits. An urgent care claim is a claim for medical care or treatment that:

1. Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
2. Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours after receiving notice of additional information required**
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days after receiving the adverse benefit determination**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
UnitedHealthcare must notify you of the appeal decision within:	**72 hours after receiving the appeal**

C. Post-Service

A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Post-Service Claims	
Type of Claim or Appeal	**Timing (Business Days)**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

D. Concurrent Care

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

III. Timing and Form of Claims Decisions

A. Weekly Accident and Sickness (Disability) Benefit Denials

An **adverse benefit determination** (*i.e.*, a "denial") for a Weekly Accident and Sickness (disability) Benefit claim is a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in the Plan.

1. Timing of Notice of Claim Denial

The Plan will make a decision on the claim and notify you of the decision within *45 days* of receipt of completed paperwork. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you 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 day*s of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund Administrator notifies you, prior to the expiration of the first *30-day extension period*, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within *30 days*.

2. Content of Notice of Claim Denial

If your claim for Weekly Accident and Sickness Benefits is denied, the Plan will provide you with written notice of the claim (whether denied in whole or in part). This notice will*:*

a. State the specific reasons for the denial;

b. Refer to the specific plan provisions on which the denial was based;

c. Describe any additional material or information necessary to perfect the claim and provide an explanation of why the material or information is necessary;

d. Describe this Plan's appeals procedures (including the Plan's appeals procedures to the Board of Trustees) and the applicable time limits;

e. If the denial was based on an internal rule, guideline, protocol, or similar criteria, you will either receive a copy of the rule or a statement that a copy of the rule, guideline, protocol or criteria that was relied on will be provided to you upon request at no charge;

f. If the denial was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and

g. Contain a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal, but note that, in general, such civil action only may be brought after the Plan's appeals procedures have been exhausted.

B. Health Care Claim Denials (Medical, Dental, Hearing, Vision, and Prescription Drug Claims)

An **adverse benefit determination** (*i.e.*, a "denial") of a medical, dental, hearing, vision, or prescription drug claim is defined as:

1. A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

a. a determination of an individual's eligibility to participate in a Plan, or

b. a determination that a benefit is not a covered benefit;

2. A reduction in or denial of a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and/or

3. Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

C. Content of Notice of Claim Denial

If your claim is denied, you will be provided with written notice of a denial of a claim (whether denied in whole or in part). Depending on the type of benefit involved with the claim, this notice will either come from UnitedHealthcare, Delta Dental, CVS Caremark, Davis Vision or Sargent Rehabilitation Center. This notice will state:

a. The specific reason(s) for the determination;

b. A reference to the specific Plan provision(s) on which the determination is based;

c. A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;

d. A description of the appeal procedures and applicable time limits;

e. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

f. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;

g. If the denial was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and

h. For **Urgent Care Claims**, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the

required determination may be provided orally and followed with written notification.

IV. Appeals Processes

A. Appealing a Denied Weekly Accident and Sickness (Disability) Benefit Claim

If your claim for Weekly Accident and Sickness Benefits is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for appeal must be made **in writing** to the Fund Office within *180 days* after you receive the notice of denial.

Appeals must be submitted **in writing** to:

The Board of Trustees
Teamsters Local 251 Health Services and Insurance Plan
1201 Elmwood Avenue
Providence, RI 02907

The appeal will be reviewed by The Board of Trustees, who are named fiduciaries of the Plan, and processed as follows:

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

You have the right to submit written comments, documents, records and other information relating to your claim. The review will take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial claim denial.

A different person/entity will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

1. Timing of Appeals Decision

Decisions on Weekly Accident and Sickness Benefits claim appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Appeal

You will receive a notice of the appeal determination. If that determination is a denial, it will include specific information. See "Notice of Decision on Appeal" in this Section for complete information.

B. Appealing a Denied Health Care Benefit Claim

If your health care claim is denied in whole or in part, you will be promptly notified by the appropriate administrator of your claim. Depending on the treatment involved, this notice will be provided by, Delta Dental, CVS Caremark, Davis Vision, Sargent Rehabilitation Center, or for medical claims, by UnitedHealthcare.

If you have a question about why your *medical* claim was denied, you may call the UnitedHealthcare Customer Service Department at 1 (866) 527-9596. If you are not satisfied after the discussion, you have the right to file a formal appeal as described below. You do not need to submit Urgent Care appeals in writing. Call UnitedHealthcare to request an appeal of a denied Urgent Care claim.

1. Filing a Written Appeal with UnitedHealthcare for Medical Benefits

If you wish to appeal a denied pre-service request for Benefits or post-service claim as described below, **you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination**.

IMPORTANT REMINDER: You do not need to submit Urgent Care appeals to UnitedHealthcare in writing. To request an Urgent Care appeal, call UnitedHealthcare at: 1(866) 527-9596*. (This is the same toll free number that's on your ID card.)*

To file a written appeal of a denied medical claim to UnitedHealthcare, send the following information:

a. Your name and address;

b. Your UnitedHealthcare identification number;

c. The Providers name and the date of medical service;

d. The reason you disagree with the denial, any previous contact with UnitedHealthcare, and the resolutions you are seeking;

e. Any additional information such as referral forms, claims, or other documentation you would like to be reviewed to support your request; and

f. Your signature.

g. **SEND ALL APPEALS OF DENIED MEDICAL CLAIMS TO**:

UnitedHealthcare-Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

The timing of the claims appeal process is based on the type of claim you are appealing, (*i.e.*, Urgent Care, Pre-Service, Post-Service, or Concurrent Care claim.

2. General Procedures: Health Care Claim Appeals

As noted previously, you have the right to appeal a denied claim for health care benefits. With the exception of Urgent Care claims, all such appeals must be made in writing. Specifically, your appeal related to the denial of a medical claim will be made by UnitedHealthcare; the denial of a dental benefit will be made by Delta Dental of Rhode Island; denied prescription drug benefits will be reviewed by CVS Caremark; denial of vision benefits will be reviewed by Davis Vision; and reviews of denied hearing benefits will be conducted by the Sargent Rehabilitation Center.

The appeals process for each of these benefits will work as follows:

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service. You have the right to submit written comments, documents, records and other information relating to your claim. The review will

take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial benefit determination.

A different person/entity will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

3. Where to File Your Appeal of (Non-Medical) Health Care Claims

For Dental Claims:
Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517
(800) 843-3582

For Prescription Drug Claims:
CVS Caremark
Prescription Claim Appeals
Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
(888) 543-5940

For Vision Claims:
Davis Vision, Inc.
Quality Assurance Department
P.O. Box 791
Latham, NY 12110
(888) 343-3470

For Hearing Benefits:
Sargent Rehabilitation Center
800 Quaker Lane
Warwick, RI 02818
(401) 866-6600

4. Timing of Appeal Decision

The Plan's determination of its decision on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims, as shown in the following paragraphs:

Urgent Care Claims: A determination will be made as soon as possible, but not later than 72 hours after receipt of your appeal.

Pre-Service Claims: A determination will be made within 30 calendar days from receipt of your appeal.

Post Service Claims: Decisions on post-service hearing benefit claim appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Concurrent Care Claims: A determination will be made before termination of your benefit.

5. Notice of Decision on Appeal

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

a. The specific reason(s) for the determination;

b. Reference to the specific Plan provision(s) on which the determination is based;

c. 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;

d. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

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

f. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other

similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

6. Filing a Second Appeal with UnitedHealthcare

Your UnitedHealthcare benefits Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

7. Grievances Unrelated to Claims

UnitedHealthcare encourages you to discuss any complaint that you may have about any aspect of your medical treatment with the health care provider that furnished the care. In most cases, issues can be more easily resolved when they are raised sooner. If, however, you are dissatisfied with a service or UnitedHealthcare's administration of covered benefits, you may access any of UnitedHealthcare's grievance procedures. In order to initiate a grievance, please call the Customer Relations Department at 1 (866) 527-9596.

The grievance procedures described in this section do not apply to claims appeals, claims of medical malpractice, or to allegations that UnitedHealthcare is liable for the professional negligence of any doctor, hospital, health care facility or other health care provider furnished covered services.

C. Filing an Appeal of an Adverse Benefit Determination with the Plan Trustees

The Trustees have full and absolute discretion, authority and power to interpret the terms of this Plan, determine all questions of coverage and eligibility and adjudicate benefit claims. The Trustees also have the authority to request any documents they believe are reasonably necessary to make these determinations. Failure to comply with the Trustees' request for information may result in a denial of your claim for benefits. All determinations made by the Board of Trustees with respect to any matters arising under the Plan, Trust Agreement and any other Plan documents shall be final and binding on all affected Plan Participants and their beneficiaries.

If your initial benefit claim is denied in whole or in part, you will be notified by the Plan or the applicable service provider if you have the right to appeal. Other than for Weekly Accident and Sickness Benefits where appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. The first level of appeal for any benefit offered under this Plan will be administered by the applicable service provider (*e.g.*, for appeals of denied medical claims by UnitedHealthcare, for denied dental claims by Delta Dental of Rhode Island, etc.).

Weekly Accident and Sickness Benefit appeals will be decided at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, the appeal will be decided by a person different form the person who made the initial claim decision and who is not a subordinate of the persons who made the initial claim decision. No deference will be accorded to the initial benefit decision.

1. General Procedure for Filing an Appeal to the Trustees

If you wish to appeal an eligibility determination or a benefit denial with the Trustees for any of the self-insured benefits offered under this Plan, then you must first exhaust any preliminary appeal procedures offered by the appropriate service provider (or as may otherwise be available under this Plan) as described previously. Then, you must submit an appeal to the Trustees in writing within **180 days** after you receive the denial of benefits or eligibility determination.

Appeals should be sent to the Board of Trustees at the address below.

Teamsters Local 251 Health Services and Insurance Plan
1201 Elmwood Avenue
Providence, RI 02907

Fund Office Telephone Numbers:
(401) 467-3323 or
(800) 542-2411

If a health care professional is consulted in connection with your appeal, the Board of Trustees will consult with a health care professional different from the person who was consulted in the initial claim decision and who is not a subordinate of the person who was consulted in the initial claim decision. Upon request, your Plan Administrator will identify any medical expert whose advice was obtained on behalf of Trustees in connection with your appeal.

You will be notified of the decision on appeal within a reasonable period of time, but no later than five days after the quarterly Trustee meeting at which your appeal is decided. If the Trustees receive your appeal less than 30 days before the next Trustee meeting, your appeal will be decided at the second Trustee meeting following the date the Trustees receive your appeal. If the Trustees receive your appeal 30 or more days before the next Trustee meeting, your appeal will be decided at the next Trustee meeting.

If special circumstances require additional time to process your appeal, you will be notified in writing of the reason for the extension and the date the claim will be decided, which will be no later than the third Trustee meeting following the date the Trustees receives your appeal.

2. If your appeal is denied, the notice of adverse benefit decision will:

a. state specific reason(s) for the adverse determination;

b. refer to specific Plan provision(s) on which the benefit determination is based;

c. state 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;

d. disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

e. explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request), if the denial is based on a Medical Necessity or Experimental treatment or similar limit; and

f. include a statement regarding your right to commence a legal action under section 502(a) of ERISA.

D. Limitations on Legal Action

You cannot bring any legal action against 251 Health Services and Insurance Plan, Plan representatives or the Claims Administrators to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this Summary Plan Description and all required reviews of your claim have been completed. Please note that you must exhaust all appeal processes listed herein prior to bringing any legal action against the Plan, Plan representatives or the Claims Administrators. If you want to bring a legal action against the Plan, Plan representative or a claim administrator, you must do so within the applicable statute of limitations period which begins to run from the expiration of the time period in which a request for reimbursement must be submitted.