



Carpenters Southwest Administrative Corporation

LOS ANGELES ADMINISTRATIVE OFFICE: 533 S Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free (800) 293-1370
LAS VEGAS ADMINISTRATIVE OFFICE: 980 Kelly Johnson Dr., Ste.180 • Las Vegas, NV 89119-3722 • Tel: (702) 851-4510 • Toll Free (800) 501-0210
www.carpenterssw.org

DECEMBER, 2002

CLAIMS AND APPEALS PROCEDURES

Applicable to Fee-For-Service Benefits and Eligibility Determinations Only – for HMO and Prepaid Dental Claims and Appeals Procedures, Refer to the Disclosure Booklets Issued by those Organizations

CLAIMS PROCEDURES

These are the procedures for filing claims for benefits from the Carpenters Health and Welfare Trust for Southern California (the Plan) effective January 1, 2003. This section also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

A. How to File a Claim

In order to receive benefits, you must file a written claim with the Administrative Office or other location indicated below. A standard claim form may be obtained from the Administrative Office by calling 213-385-0551 or toll free at 1-800-252-9255. There are separate claim forms for medical, dental and vision expenses.

If your health care provider submits a claim electronically, it must include the following information:

- Participant name
- Patient name
- Patient's relationship to the participant
- Patient Date of Birth
- SSN of participant or retiree
- Participant's Union Local number
- Date of Service
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Provider's billing name and address
- If treatment is due to accident, accident details
- Information on other insurance coverage, if any

Arizona
Satellite Office
4547 W. McDowell Rd.
Phoenix, AZ 85035-4124
(602) 352-6805

New Mexico
Satellite Office
1021 Cardenas Dr., NE
Albuquerque, NM 87110-6615
(505) 266-8869

Utah
Satellite Office
8149 S. Welby Park Drive
West Jordan, UT 84088
(801) 282-6528

SPECIFIC INSTRUCTIONS

For Life Insurance

Whenever there is a claim, a certified copy of the death certificate, carrying the deceased's Social Security number, should be sent to the Administrative Office immediately. If a copy of the death certificate is not available, ask the Administrative Office for a form to be filled out by the physician who is certifying to the death. Payment of the claim will be made promptly upon receipt of all necessary proofs by the Administrative Office.

For Accidental Death and Dismemberment Insurance

The Administrative Office should be notified immediately of a claim and the necessary forms will be sent to the claimant so that payment of the claim may be made promptly.

The following claim procedures for Hospital Services, Medical Services, Medical Supplies, Prescription Drugs, Dental Services and Vision Care apply only to the Trust's Fee-For-Service Plans.

The Plan requires that you obtain pre-authorization for the following services:

- Partial hospitalization for psychiatric care,
- Hospice care,
- Hospital and anesthesia services in connection with dental care, and
- Prescribed nutritional supplements.

For Hospital Services - Fee-For-Service Plan Only

When you or a Dependent are hospitalized, show your Carpenters Trust Identification Card to the hospital admitting office. Instruct them to submit the claims to:

**Carpenters Health and Welfare Trust
for Southern California
P.O. Box 17973
Los Angeles, California 90017-0973**

For Medical Services - Fee-For-Service Plan Only

Obtain a claim form from your Union Office or the Administrative Office. Complete the upper part of the form and have the provider complete the lower part.

After treatment is rendered, the completed claim form should be mailed to the Carpenters Health and Welfare Trust at the above address.

For Medical Supplies - Fee-For-Service Plan Only

Bills submitted for appliances necessary to treat your illness or injury should include the date purchased, for whom prescribed and the prescribing physician's name. A separate form must be filed for each patient.

Under this procedure, prescription drug benefits are not assignable. You pay the pharmacist — Caremark reimburses you.

Cash register receipts, canceled checks or handwritten receipts are not acceptable.

For Dental Services - Fee-For-Service Plan Only

The Fee-For-Service Dental Plan suggests that pre-authorization be obtained for charges of \$500 or more — be sure to discuss this with your dentist.

- ❑ Obtain a dental claim form from your Union Office or the Administrative Office.
- ❑ On your first appointment, present your Carpenters Identification Card advising your dentist that you are covered by the Carpenters Health and Welfare Trust for Southern California Dental Plan.
- ❑ Have your dentist complete the claim form.
- ❑ If your dental treatment is expected to cost \$500 or more, a dental claim form indicating the treatment plan and x-rays should be submitted to the Administrative Office, at the address below, before the services are performed.
- ❑ Forward the claim to:

**Carpenters Health and Welfare Trust
for Southern California**
P.O. Box 17973
Los Angeles, California 90017-0973

- ❑ For your dependent child's orthodontic services, please follow the preceding instructions. After pre-authorization is obtained from the Administrative Office, a claim should be submitted to the above address when the initial appliance is installed. Thereafter a claim should be submitted each month for the dentist's normal monthly charge until the maximum payment of \$1,000 for all orthodontic procedures has been reached. **Remember, services must be performed by a dentist who limits his practice to the specialty of orthodontics in order to receive benefits from the Plan.**

Before treatment is started, be sure to discuss with your dentist the total amount of his fee to enable you to determine what portion of the total bill you will be required to pay.

What is NOT a "claim" under these procedures

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. For example, calling the Administrative Office and asking whether the Fund covers speech therapy is not a claim for benefits.
- A request for pre-authorization regarding the Plan's coverage of a medical treatment, service or supply that your physician has recommended is not a "claim" under these procedures unless the Plan requires you to obtain pre-authorization. For example, a request for pre-authorization of an appendectomy is not a mandatory condition for receiving benefits and will not be treated as a claim for benefits. See the Summary Plan Description (SPD) discussion of the pre-authorization requirements.
- According to federal regulations, a "claim" does not include an attempt to fill a prescription at a retail pharmacy in the Caremark network. On the other hand, a "claim" does include attempts to have a prescription filled through the Caremark mail order program. However, in either case, if your request for a prescription is denied, in whole or in part, you may file an appeal by using the procedures described below.
- Requests for determination of whether a person is eligible for benefits will not be considered a claim under these procedures *unless a specific claim for benefits is denied for lack of eligibility.*

B. When Claims Must Be Filed

Claims should be filed within 90 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred.

C. Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Administrative Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Even if you have designated an authorized representative to act on your behalf, you must personally sign a claim form and file it with the Administrative Office at least annually.

D. Fee-for-Service Medical, Dental and Vision Benefits

The claims procedures for fee-for-service benefits will vary depending on whether your claim is for a **Pre-Service Claim**, a **Concurrent Care Claim**, a **Post-Service Claim**, or a **Disability Claim**. Read each section carefully to determine which procedure is applicable to your request for benefits:

1. Pre-Service Claims – Applicable only to benefits that require pre-authorization

A **Pre-Service Claim** is a request for pre-authorization of a treatment, supply or service for which the Plan requires a showing that the treatment, supply or service is Medically Necessary before medical care is obtained.

If you fail to pre-authorize the following services your benefits may be denied.

- Hospice care
- Hospital and anesthesia services in connection with dental care
- Partial hospitalization in connection with Psychiatric Care
- Prescribed nutritional supplements

EMERGENCY CARE DOES NOT REQUIRE PRE-AUTHORIZATION. However, the amount payable for emergency care is subject to the Plan's limits and exclusions that are otherwise applicable.

Pre-authorization may be obtained as follows:

- **You or your provider may telephone** 213-385-0551 or 1-800-252-9255.
- Delivery to the Administrative Office, 533 So. Fremont Avenue, Los Angeles, CA 90071, by you or your authorized representative.

Voluntary Pre-notification

Pre-authorization is not required as a condition for receipt of benefits for the following services, supplies and treatments. Nevertheless, it may be to your advantage to seek pre-notification of the following services, supplies, and treatments to determine how much of the bill will be payable by the Plan:

- Surgical procedures where the surgeon's fee is expected to exceed \$1,500
- Skilled nursing services
- Physical therapy services
- Home I.V. infusion therapy
- Home uterine activity monitoring
- Durable medical equipment
- MRIs and CAT scans
- Dental treatment where the fees are expected to exceed \$500

If you seek pre-authorization of any of these treatments, supplies or services, the Administrative Office or other medical review firm will review the proposed treatment, supply or service to determine whether it is Medically Necessary. You will be notified of a preliminary finding on the issue of medical necessity and whether the Plan is likely to cover the cost of the treatment, supplies or services. You can then decide whether to obtain the treatment or

services. However, the decision to get treatment, supplies or services will be between you and your health care provider alone. The Plan does not make medical judgments, and there is no right of appeal of any preliminary finding on the issue of medical necessity.

If you improperly file a **Pre-Service Claim**, the Administrative Office will notify you as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes (i) your name, (ii) your specific health condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed **Pre-Service Claims**, you will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Plan. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

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 and/or your doctor 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 period for making the determination is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has *15 days* to make a decision on a **Pre-Service Claim** and notify you of the determination.

2. Concurrent Care Decisions

A **Concurrent Care Decision** is a decision that is made after an initial approval was made and that may result in a reduction, termination or extension of a benefit. (An example of this would be an inpatient hospital stay for mental illness originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

In the event the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and a determination is made by the Plan to reduce or terminate such course of treatment (other than by plan amendment or termination) or the number of treatments, you will be notified as soon as possible, but in any event early enough to allow you to file an appeal and to have that appeal decided before the benefit is reduced or terminated.

3. Post-Service Claim

The following procedure applies to **Post-Service Claims**, which are all claims that are not described in sections 1 and 2 above. (An example is a claim submitted for payment after health services and treatment have been obtained.) The procedures to be followed when filing a Post-Service Claim are outlined in Section A. How to File a Claim.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a signed claim within the past calendar year period. Mail any further bills or statements for any medical, hospital, prescription drug, dental or vision services covered by the Plan to the Administrative Office as soon as you receive them.

Ordinarily, you will be notified of the decision on your **Post-Service claim** within *30 days* from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to *15 days* if the extension is necessary due to

matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by 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 period for making the determination 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). The Plan then has *15 days* to make a decision on a **Post-Service Claim** and notify you of the determination.

4. Disability Claims

A **Disability Claim** is any claim that requires a finding of total disability as a condition of eligibility. For example, a claim for benefits requiring a determination of disability for disability hours credit under the eligibility rules for active carpenters will be treated as a Disability Claim.

For **Disability Claims**, the Plan will make a decision on the claim and notify you of the decision within *45 days* after receipt of the claim by the Plan. 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 the date by which the Plan expects to render a decision. This notification will occur before the expiration of the 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within *30 days* 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 Plan administrator notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, prior to the expiration of the first 30-day extension period.

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 period for making the determination 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*.

For Disability Claims, the plan reserves the right to have a Physician examine you (at the Plan's expense), as often as is reasonable while a claim for benefits is pending.

F. Notice of Decision

You will be provided with written notice of a denial of a claim, whether denied in whole or in part. This notice will state:

- The specific reason(s) for the determination
- Reference 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 under ERISA Section 502(a) following an adverse benefit determination on review.

- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the determination and that such explanation is available upon request at no charge.
- If the determination 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.

For **Pre-Service Claims**, you will receive notice of the determination orally or in writing even when the claim is approved.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Administrative Office within *180 days* after you receive notice of denial.

A. Review Process

The review process works as follows:

You have the right to submit comments, documents, records and other information in support of your claim for benefits. Upon request and free of charge, the Plan will provide you with reasonable access to and copies of all documents, records, or other information 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) in connection with the claim, 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.

Upon request, 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.

A different person will review your claim and such person will not be a subordinate of the person who originally denied your claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the claim.

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 will be consulted. Such professional will not be an individual who was consulted in connection with the initial determination that is the subject of the appeal, or any subordinate of such individual.

B. Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Administrative Office.
- **Post-Service Claims:** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Health Care Committee 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 may 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.

- **Disability Claims:** The decision will be made in the same manner as for Post-Service Claims.

C. Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference 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, records, and other information relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline, protocol or similar criterion was relied upon by the Plan, you will receive either a copy of the rule, guideline, protocol or similar criterion or a statement that it is available upon request at no charge.
- 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.

D. Limitation on When a Lawsuit may be Started

You may not file a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.