December 2002
Revised and Restated September 2004

Dear Participant:

The Department of Labor's Pension and Welfare Benefits Administration has issued new claims and appeals regulations that will be applicable to the Connecticut Carpenters Health Fund (the "Plan") effective January 1, 2003. The new procedures create maximum time periods for acting on claims and appeals. For claims first filed after 2002, these new procedures replace the chart on the bottom half of page 14 of the 2001 version of your Summary Plan Description (SPD). Be sure to keep a copy of this letter with your SPD for future reference.

Claims and Appeals Procedures

I. GENERAL PROVISIONS

This section describes the procedures for filing claims for benefits from the Connecticut Carpenters Health Fund. It 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. These procedures do not apply to claims for life insurance/accidental death and dismemberment benefits because those claims are handled by the insurance company that pays those benefits. If you would like a copy of the procedures that apply to insurance claims, call the Fund Office.

A. How to File a Claim

A claim for benefits is a request for Plan benefits made in accordance with these procedures. In order to file a claim for benefits offered under this Plan, you must complete, sign and submit to the Fund Office one health claim form for your family each calendar year so that your records are set up for claims submitted later during the calendar year. When you incur expenses, send the claim form that you get from your

provider(s) to the address on your I.D. Card. General inquiries about the Plan's provisions or eligibility questions that are unrelated to any specific benefit claim, or requests to add or improve the Plan's benefits will not be treated as claims for benefits. In addition, a request for pre-approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A health claim form may be obtained from the Fund Office by calling: 1-800-922-6026 or by downloading a form from the Connecticut Carpenters' website at:
http://www.ctcarpentersfunds.org/
All of the following information must be completed on the claim form that you get from your provider(s) in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

- Member's name and identification number
- Member's address
- Member's date of birth
- Member's marital status
- Spouse's name and identification number (if applicable)
- Spouse's date of birth and employment status (if applicable)
- Name, address and telephone number for spouse's employer
- Patient name and address (if different from Member)
- Patient's relationship to insured
- Patient date of birth
- Patient's sex
- Patient's student status
- Was condition related to patient's employment, or accident
- Date of service
- Date patient able to return to work
- Date of total/partial disability
- Name of referring physician
- Hospitalization dates, if applicable
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition* or later, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition* or later, *Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge, amount paid and balance due
- Federal taxpayer identification number (TIN) of the provider
- Provider billing name and address
- Coordination of benefits information

B. When Claims Must Be Filed

Claims must be filed within 365 days from the date the charges were incurred. Claims for Weekly Disability Income Benefits must be filed no later than 90 days from the date

your disability began. Claims filed after these dates will not be considered or paid by the Health Fund.

C. When a Claim is Considered Received by the Health Fund

(1) Post-Service Claims

A **post-service claim** for benefits (as defined in section II.A.(3) of these procedures) is considered received as follows:

(a) For medical and dental claims

Claims must be submitted to Anthem or the Fund as shown on your ID card. The deadlines for claims decisions will begin to run on the first business day when the claim is:

- received by the Fund Office, by U.S. mail or hand-delivery, at the following address:

  Connecticut Carpenters Health Fund
  10 Broadway
  Hamden, CT 06518-2699
  Tel. 1-800-922-6026

- submitted electronically or by mail by your provider and received at the Fund's designated EDI address or mailing address for that type of claim that will be listed on your Member ID card.

(b) For vision claims

- On the first business day when the out-of-network claim is received by U.S. mail to Davis Vision at the following address:

  Davis Vision
  Vision Care Processing Unit
  P.O. Box 971
  Schenectady, NY 12301

- On the first business day when the claim is submitted electronically by your provider and received by Davis Vision.

(c) For Weekly Disability Income (Disability Claims)

- On the first business day the claim is received by U.S. mail or hand-delivered to the Fund Office at the following address:

Connecticut Carpenters Health Fund
10 Broadway
Hamden, CT 06518-2699
Tel. 1-800-922-6026

(2) Urgent, Pre-Service and Concurrent Claims

Urgent, pre-service and concurrent claims (as defined in section II.A. of these procedures) are generally requests for preauthorization or precertification of a treatment or hospital stay. (You should refer to your SPD for a listing of those services that require precertification.) An urgent, pre-service or concurrent claim is considered received when a telephone call is made to Hines at the following telephone number 1-800-944-9401, or your provider electronically contacts Hines at its EDI address requesting precertification.

(3) Prescription Drug Claims

When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

D. Claims Communications

All claims communications required to be sent to the patient pursuant to these procedures will be addressed to and sent to the Member unless the patient makes a written request to the Health Fund office specifically requesting that any claims communications be sent under the patient's name and/or to a different address. Any requirement that communications be sent "in writing" shall be satisfied if sent via US Postal Service or any expedited mail service, electronically or by facsimile.

E. 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 Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. In connection with an **Urgent Care Claim** (defined below), a health care professional with knowledge of your medical condition (and to the extent necessary to process your Urgent Care Claim, a physician affiliated with or other employee of the facility in which you are confined or from which you are receiving urgent care treatment), may act as an authorized representative without you having to complete the special authorization form. For purposes of these procedures, notice to your authorized representative will constitute notice to you.

II. MEDICAL BENEFITS

The claims procedures for medical benefits will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Care 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:

A. Definitions and Time Limits

(1) Pre-Service and Urgent Care Claims

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for all hospital admissions (including mental health and substance abuse admissions), inpatient rehabilitation, certain prescriptions, and air ambulances.

Important: If you fail to pre-certify these services, Plan benefits will be reduced or in some cases, no Plan benefits will be payable for those services.

The Fund has a contract with Hines & Associates to administer Pre-Service, Urgent and Concurrent Care Claims for all hospital admissions and for inpatient rehabilitation.

For properly filed **Pre-Service Claims**, you and/or your doctor 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 Hines. 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 Hines 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 deemed to be denied, without further notice from Hines or the Plan. 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 the date you respond to the request (whichever is earlier). Hines then has 15 days to make a decision on the **Pre-Service Claim** and notify you of the determination.

If you or your doctor improperly file a **Pre-Service Claim**, Hines will notify you orally (unless you specifically request written notice, then in writing) 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 medical condition or symptom, and (iii)

a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

An **Urgent Care Claim** is any claim for medical care or treatment where the timing of a claim determination:

(1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim** within the meaning described above, will be treated as an **Urgent Care Claim**. Absent a determination by that physician, Hines will determine whether your claim is an **Urgent Care Claim**, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you are requesting precertification of an **Urgent Care Claim**, the time deadlines are different than those that apply to Pre-Service Claims. Hines will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical condition, but not later than 72 hours after receipt of the claim by Hines. The determination will also be confirmed in writing within 3 days.

If an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, Hines will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours of receiving notice. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after Hines receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

If you or your provider improperly file an **Urgent Care Claim**, Hines will notify you orally and/or in writing as soon as possible, but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

(2) Concurrent Claims

A **Concurrent Claim** is a claim for additional treatment or hospital days or a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient

hospital stay originally approved 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 at the same time or "concurrently" with the provision of treatment.

A reconsideration of a benefit with respect to a **Concurrent Claim** that involves the *termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by Hines as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon by Hines within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

(3) Post-Service Claims

The following procedure applies to **Post-Service Claims**. A **Post-Service Claim** is a claim that is not a **Pre-Service, Urgent Care, or Concurrent Claim** (for example, a claim submitted for payment after health services and treatment have been obtained).

1. Obtain a health claim form from the Fund Office if you have not already filed your annual form, and complete the employee's portion of the claim form. Failure to complete the form could delay processing of your claim.

2. Have your Physician give you a completed HCFA health insurance claim form.

3. Attach all itemized UB-92 Hospital bills and/or doctor's statements that describe the services rendered.

You do not have to submit an additional claim form with your bills or statements, if you have filed the annual health claim form during the calendar year. **Mail any further bills or statements for any medical or hospital services covered by the Plan to the address shown on your I.D. Card as soon as you receive them.** Your provider may also submit bills on your behalf.

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 once 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 is deemed denied, without further notice from the Plan. 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). The Plan then has 15 days to make a decision on a **Post-Service Claim** and notify you of the determination.

(4) Disability Claims (Weekly Disability Income Benefits)

You must file a claim for Weekly Disability Income Benefits with the Fund Office no later than 90 days after the date your disability began.

For **Disability Claims**, the Plan will make a decision on the claim and notify you of the decision within 45 days. 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 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, 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 deemed to be denied, without further notice from the Plan. 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, or the need for an extension, within 30 days.

B. Notice of a Denied Claim

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 (including voluntary appeals, if any) 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 or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it 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.

III. APPEAL PROCESS FOR DENIED CLAIMS

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 Fund Office and must be received within 180 days after you receive notice of denial. Appeals involving **Urgent Care Claims** may be made orally by calling the Health Fund Administrator at 1-800-922-6026 during normal business hours. During non-business hours, you should call the Fund's answering service **for Urgent and Concurrent Claim appeals only**. The answering service's phone number will be available on the Fund's after hours recorded message at the above number. All other calls must be made during normal business hours, which are 8:00 a.m. to 4:30 p.m., Monday through Friday, excluding Holidays.

A. Appeal Process

The appeal process works as follows:

(1) Urgent, Pre-Service and Concurrent Claim Appeals

For **Urgent, Pre-Service and Concurrent Claim Appeals**, there is one level of appeal. Appeals must be made in writing, except that appeals of Urgent Care Claims may be made in writing or orally, to the Fund Office. A sub-committee consisting of the Union Trustee Co-Chair, the Employer Trustee Co-Chair, and the Health Fund Administrator, or their alternates if any of them is unavailable, will review Urgent, Pre-Service and Concurrent Claim appeals. Neither the Health Fund Administrator nor her alternate will participate in Appeals regarding pre-certification of certain prescriptions or of air ambulance charges. In certain circumstances such as Urgent Claim appeals where medical conditions exist that require an expedited review process, appeals may be made orally via telephone.

(2) Post-Service and Disability Claim Appeals

For **Post-Service and Disability Claims appeals**, there is a two-level appeal process. Appeals must be made in writing to the Fund Office. The first level of appeal will consist of a review by the Health Fund Administrator. If the appeal is denied, you have the right to a second level of appeal consisting of review by the full Board of Trustees. Your request for a second level of appeal must be made in writing to the Fund Office and must be received within 60 days after you receive notice that the first level appeal was denied.

B. Information To Which You Are Entitled

You have the right to review 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) in making the decision; 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, who 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 than the one who originally denied the claim or the previous appeal. The reviewer will not give deference to the previous adverse benefit determinations. 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 will be consulted.

C. Timing of Notice of Decision on Appeal

(1) Pre-Service or Concurrent Claims

You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Fund Office.

(2) Urgent Care Claims

You will be notified of a decision on your appeal, either in writing or electronically within 72 hours of receipt of the appeal by the Fund Office.

(3) Post-Service Claims

For first level appeals, a decision will be made on the appeal within 30 days of receipt of the appeal by the Health Fund Administrator. For second level appeals, decisions 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, the Fund Office will give you written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.

(4) Disability Claims

For first level disability claim appeals a decision will be made by the Health Fund Administrator within 45 days of receipt of the appeal at the Fund Office. If the Health Fund Administrator determines that special circumstances require an extension of time, then you will receive a written notice of the extension before the end of the 45 day period. The notice will include the reasons required for the extension and the approximate date the Plan expects to make a decision.

For second level appeals, decisions 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, the Fund Office will give you written notice of the decision as soon as possible, but no later than 5 days after the decision has been reached.

D. 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 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 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

- 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.

IV. LAWSUITS AND LIMITATIONS

You may not start a lawsuit to obtain benefits until after you have exhausted all levels of appeal and final decisions have been reached on those appeals, 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. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit to recover Plan benefits may be started more than 15 months after the date of loss (for example, the date you incurred the expense you are seeking to have the Plan pay) upon which the lawsuit is based. Because the Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, the issue in a lawsuit will be limited to whether or not the Board of Trustees (or its delegates, including the subcommittee for Urgent Care, Pre-Service and Concurrent Claims) acted arbitrarily or capriciously in making its determination.

Adopted by the Health Fund's Board of Trustees on September _____, 2004.

Union Trustee	Association Trustee
_____	_____
Glenn Marshall	John B. Farnham