

# *City of Gulfport*

## Group Health Plan Claim Procedures

Claim Procedures: These claim procedures are furnished as a separate document that accompanies the *City of Gulfport* Group Health Plan Summary Plan Document. These procedures describe how benefit claims and appeals are made under the *City of Gulfport* Group Health Plan. Consult the Summary Plan Document for details regarding the benefits provided under the *City of Gulfport* Group Health Plan.

### **1. Introduction**

Under Department of Labor (DOL) regulations, claimants are entitled to a full and fair review of any claim made under the Plan. The procedures described in this document are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

These claim procedures are furnished as a separate document that accompanies the *City of Gulfport* Group Health Plan Summary Plan Document (SPD). These procedures describe how benefit claims and appeals are made and decided under the Group Health Plan. Consult the SPD for details regarding the benefits provided under the Group Health Plan.

### **2. Definitions**

*Authorized Representative:* An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of such form, recognize a health care professional with knowledge of the claimant's medical condition as the claimant's authorized representative unless the claimant provides specific written direction otherwise. An Appointment of Authorized Representative form may be obtained from and completed forms must be submitted to:

S.A.S.

Attn: Authorized Representative

PO Box 3209

Gulfport, MS 39505-3209

228/865-0514 or 1-888-601-6742

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notification regarding decisions, unless the claimant provides specific written direction otherwise.

*Claim:* A claim is any request for a plan benefit(s) made in accordance with these claim procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

*Claimant:* You become a claimant when you make a request for a plan benefit(s) in accordance with these claim procedures.

*Day:* When used in these claim procedures, the term day means calendar day.

*Incorrectly-Filed Claim:* Any request for benefits that is not made in accordance with these claim procedures is called an incorrectly-filed claim.

*Plan Administrator / Named Fiduciary:* **City of Gulfport** is the plan administrator and named fiduciary under the plan responsible for making claim and appeal decisions. **City of Gulfport** has the discretionary authority to interpret the plan in order to make benefit decisions as it may determine in its sole discretion. **City of Gulfport** also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the plan.

### **3. Types of Claims**

There are four categories of claims, each with somewhat different claim appeal rules. The DOL regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined.

*Pre-Service Claim:* A claim is a pre-service claim if the SPD specifically conditions receipt of the benefit, in whole or in part, on an authorization in advance of obtaining the medical care – unless the claim involves urgent care. Benefits under this plan that require prior authorization are specifically noted in the SPD.

*Urgent Care Claim:* An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would – in the opinion of a physician with knowledge of the claimant's medical condition – subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the plan will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

*Post-Service Claim:* A post-service claim is any claim for a benefit under this Plan that is not a pre-service claim or an urgent care claim.

*Concurrent Care Claim:* A concurrent care decision occurs where the plan authorizes an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the authorization results in a reduction or termination of the initially authorized period of time or number of treatments; and (2) where an extension is requested beyond the initially authorized period of time or number of treatments.

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claim procedures, the claim may be re-characterized. If you have any questions regarding the type of claim and/or what claim procedure to follow, contact:

S.A.S.  
PO Box 3209  
Gulfport, MS 39505-3209  
228/865-0514 or 1-888-601-6742

#### **4. How to File a Claim for Benefits**

Except for urgent care claims, a claim for benefits is made when a claimant submits a written Claim for Benefits form to (requests for claim forms can also be obtained from):

S.A.S.  
Attn: Claims  
PO Box 3209  
Gulfport, MS 39505-3209  
228/865-0514 or 1-888-601-6742

A Claim for Benefits form will be treated as received by the plan on the date it is hand-delivered to the above address or on the date that is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

*Post-Service Claim:* A post-service claim shall be filed within ninety (90) days following receipt of the medical service, treatment or product to which the claim relates unless it was not reasonably possible to file the claim within such time and the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than twelve (12) months after the date of receipt of such services, treatment or product to which the claim relates.

*Urgent Care Claim:* An urgent care claim for benefits may be submitted to: S.A.S., Medical Management, P.O. Box 3209, Gulfport, MS 39505, or called to 228/865-0514, or faxed to 228/865-7226. The claim should include at least the following information: (1) the identity of the claimant, (2) a specific medical condition, and (3) a specific treatment, service or product for which prior authorization is requested.

*Incorrectly-Filed Claim:* These claim procedures do not apply to any request for benefits that is not made in accordance with these claim procedures, except that in the case of an incorrectly-filed pre-service claim, the claimant shall be notified as soon as possible but no later than five (5) days following receipt by the plan of the incorrectly-filed claim; and in the case of an incorrectly-filed urgent care claim, the claimant shall be notified as soon as possible but no later than twenty-four (24) hours following receipt by the plan of the incorrectly-filed claim. The notice shall explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the claimant.

#### **5. Timeframe for Initial Benefit Claims Decisions**

*Urgent Care Claim:* The plan shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than two (2) working days after receipt of the claim.

*Pre-Service Claims:* The plan shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than two (2) working days after receipt of the claim.

*Concurrent Care Extension Request:* If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least twenty-four (24) hours prior to the end of the initially authorized period of time or number of treatments, the claim shall be decided within no more than twenty-four (24) hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

*Concurrent Care Early Termination:* A decision by the plan to reduce or terminate an initially-authorized course of treatment is an adverse benefit decision that may be appealed by the claimant under these procedures. Notification to the claimant of a decision by the plan to reduce or terminate an initially-authorized course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

*Post-Service Claim:* The plan shall decide an initial post-service claim within reasonable time but no later than thirty (30) days after the receipt of the claim.

*Timeframe Extensions:* Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. If the plan is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one fifteen (15) day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

*Incomplete Claims:* If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

*Incomplete Urgent Care Claims:* If an urgent care claim is incomplete, the plan shall notify the claimant as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim. The notification may be made orally to the claimant, unless the claimant requests written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than forty-eight (48) hours, within which the claim must be completed. The plan shall decide the claim as soon as possible but not later than forty-eight (48) hours after the receipt of the specified information or the end of the period of time provided to submit the specified information.

*Other Incomplete Claims:* If a pre-service or post-service claim is incomplete, the plan may deny the claim or may take an extension of time, as described above. If the plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than forty-five (45) days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided, the plan shall decide the claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

## **6. Notification of Initial Benefit Decision by Plan**

*Pre-Service and Urgent Care:* Written notification of the plan's decision on a pre-service or urgent care claim shall be provided to the claimant whether or not the decision is adverse.

*Definition of Adverse:* A decision on a claim is adverse if it is a denial, reduction, or termination of or a failure to provide or make payment, in whole or in part, for a benefit.

*Notification of Adverse Benefit Decision:* Written notification shall be provided to the claimant of the plan's adverse decision on a claim and shall include the following:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, disclose either an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Notification of the plan's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later than one (1) day after the oral notice.

## **7. How to Appeal an Adverse Benefit Decision**

A claimant (or authorized representative) or the attending physician on behalf of the claimant has the right to request an appeal to an adverse benefit decision and that such review is full and fair. Pre-service and post-service claims have a two level appeal. Whereas concurrent care claims and urgent care claims have a single level of appeal since a review was initially performed on these claim types when a Claim for Benefit was received by the plan. An initial appeal must be filed in writing on a Request for Review form within 180 days following the receipt of the notification of an adverse benefit decision, or else you will lose your right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit. In the event that a pre-service or post-service claim is denied after the initial appeal, a second appeal can be requested. It must be submitted in writing on a Request for Review form within a reasonable period of time appropriate to the medical circumstances but not later than thirty (30) days after receipt of the notification of denial of the initial appeal.

An exception is made for an appeal of a decision by the plan to reduce or terminate an initially approved course of treatment (concurrent care). An appeal for a concurrent care adverse benefit decision must be filed within 30 days of the claimant's receipt of the notification of the plan's decision to reduce or

terminate. Failure to comply with this important deadline may cause the claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

A Request for Review form can be requested from and must be submitted to: *Benefit Appeals*, at the address specified in the initial notification of benefit decision or on the Explanation of Benefits (EOB). Any request for appeal should state why the benefit decision is incorrect. A claimant has the right to submit documents, written comments, or other information in support of an appeal. Once a request for appeal is received, the claimant or the provider may be advised if additional information is needed to finalize the decision. If this additional information (e.g. medical records, etc) is not received within forty-five (45) days of request for use in making a decision on an appeal, the Plan Administrator has the right to deny any appeal.

In light of the shortened timeframes for decisions of urgent care claims, the claimant (or authorized representative) or attending physician may request an expedited single level appeal by telephone at 228/865-0514, by facsimile at 228/865-7226, or by any similarly rapid communication method. The appeal should include the identity of the claimant, a specific medical condition or symptom, a specific treatment, service or product for which authorization is requested, and any reasons why the appeal should be processed on a more expedited basis. The appeal determination for an expedited appeal shall be made over the phone within one (1) working day. Expedited appeals which do not resolve a difference of opinion may be submitted through the standard appeal process.

## **8. How Your Appeal will be Decided**

The initial appeal of an adverse benefit decision will be reviewed and decided by a representative of the Plan Administrator. The person who reviews and decides an initial appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The initial appeal must be submitted on a Request for Review form within 180 days of the initial adverse benefit decision.

The review will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. No deference will be given to the initial benefit decision.

In the case of a claim denied on the grounds of a medical judgment, a health care professional with appropriate training and experience will be consulted. The health care professional consulted on appeal will not be the same individual who is consulted, if any, regarding the initial benefit decision or appeal denial or be a subordinate of that individual.

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the plan.

All necessary information in connection with an urgent care appeal shall be transmitted between the plan and the claimant by telephone, facsimile, or e-mail.

## **9. Timeframes for Deciding Benefit Appeals**

*Urgent Care Claim:* An appeal for an urgent care claim shall be made as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt by the plan.

*Pre-Service Claim:* An initial appeal for a pre-service claim shall be made within a reasonable time appropriate to the medical circumstances but no later than fifteen (15) days after receipt by the plan. A second appeal for a pre-service claim shall be made within a reasonable time appropriate to the medical circumstances but no later than fifteen (15) days after receipt by the plan.

*Post-Service Claims:* An initial appeal for a post-service claim shall be made within a reasonable period but no later than thirty (30) days after receipt by the plan. A second appeal for a post-service claim shall be made within a reasonable period but no later than thirty (30) days after receipt by the plan.

*Concurrent Care Claims:* An appeal of a decision by the plan to reduce or terminate an initially authorized course of treatment for a concurrent care claim shall be made before the proposed reduction or termination takes place. The plan shall decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

## **10. Notification of Decision on Appeal**

A decision on appeal is adverse if it is a denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit. Written notification of the decision on appeal shall be provided to the claimant whether or not the decision is adverse. The notice shall be written in a manner calculated to be understood by the claimant and shall include the following:

- the specific reason(s) for the appeal decision;
- a reference to the specific plan provision(s) on which the decision is based;
- a statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination; and
- if the decision involves scientific or clinical judgment, disclose either and explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge on request.

Notification of an adverse decision on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than one (1) day after the oral notice.

If you have any questions about these claim procedures, contact: S.A.S., PO Box 3209, Gulfport, MS, 39505, 228/865-0514.