FOREMEN'S UNION

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BULLETIN _____ **DECEMBER 2016**

STOP WORK MEMBERSHIP MEETING

THURSDAY, December 1, 2016 7 PM at the Cruise Terminal S. P. 93

Executive Board: This month's meeting will be Wednesday, November 30, 2016 at 11:30 AM.

Health Benefit Claims

Brothers and Sisters of Local 94

We all acknowledge the confusion around us about how to handle our Health Insurance coverage and more importantly how to resolve demands for payment of medical bills. Be assured that your Officers are doing all we can possibly do to make these tasks easier for you and your family. However, to meet these goals we now need your help.

We need every member to be more diligent and proactive in your selection of health providers with special attention paid to whether you are selecting an "in-network" or an "out of network" provider. Also, we need your help to address recent demands from providers who are claiming members have overdue accounts for previous services by being more aware of the necessary deadlines relating to demanding payment of overdue bills, and what you must do under the requirements of the Health Plan to get those bills paid.

To help you become more aware of these deadlines, and how to handle those demand letters for payments, the Officers have prepared a timeline of how to handle denials of payments. This timeline graph should help you navigate the waters of the complexities of the health insurance business.

Remember, you have a right to challenge the denial of payment. That right is guaranteed by law and the Health Plan regulations and is outlined in your Supplemental Summary Plan Description (SSPD) booklet (*if you do not have one please ask for one because this booklet is very important and helpful*).

However, you must pursue this right or it will be lost. The attached flow chart sets forth the appeal process for each step. It also explains what you are expected to do during those steps.

As noted at the bottom, an appeal is solely and exclusively your decision and your responsibility. The only person or people that are made aware of all the documents and decisions in written correspondence is the claimant (you the member), Plan personnel, the Trustees and the Arbitrator. It is your responsibility to take note and follow your timelines.

This process is not new, but is being sought by members more often these days. Should you have questions or need assistance in starting or understanding this process beyond the enclosed document, please see your Local Officers, the Southern California Area Welfare Director, or the ILWU-PMA Benefit Plans Office (the Plan) directly.

Brothers and Sisters, you are not alone in resolving your claims, but unfortunately it takes you to initiate this process and seek the necessary assistance. Each of the locals in your area have taken the time to provide you with the tools you will need to make this process successful for you.

Please review the enclosures to familiarize yourself with the appeal process, so you can understand your rights and responsibilities. Remember to always review your Explanation(s) of Benefits (EOBs) so you will know when your claim is considered a "true denial" and you may have to file for an appeal with the Plan. This is your responsibility and has become increasingly more important.

Fraternally,

Daniel G. Miranda
President

Edward Alexander
Vice President

Mike Trudeau
Secretary – Treasurer

Member Has Treatment

Provider bills treatment - the provider has one year to bill if they are in network. If they are out of network the provider has three years to bill. (Plan has **30 days** to render a decision, possibly **45 days** if they notify the member in advance of needing more time)

- Payment is made
  - EOB showing payment is sent
- Payment is denied
  - EOB is sent denying claim (Member has **180 days** to file for an appeal)
    - Member pays bill
    - Member files for the first step of the appeal process (Full and Fair) Member also requests documents related to case (Documents sent in about one month) (The Trustees have **60 days** to render a decision)
      - The Plan overturns the denial
        - (The claim is paid) EOB sent
      - The Plan considers the case re-denied (A letter of re-denial is sent with the instructions regarding the arbitration option – Member can move their case to arbitration and have **180 days** to request)
        - The member requests that their case moves to arbitration (the member has two options – an in person hearing or conduct it in written form)

1. In person hearing:
   A. The Plan will send a letter with the date of their hearing usually about 4 months in the future. That hearing is held in San Francisco in front of the Trustees and the Arbitrator.
   B. The member will be given an opportunity to argue why the Plan should not have denied their claims
   C. The Trustees get to argue why the denial was appropriate
   D. The Arbitrator will make a decision within **30 days** of this hearing.

2. Written Arbitration:
   A. The Plan sends a letter confirming their request to move their case to arbitration – that letter will give them a date that gives the member approximately 4 weeks to turn in their "opening statement." (The opening statement is where the member gets to argue why their claims should not have been denied)
   B. That opening statement is sent to the arbitrator and the Trustees and then the Trustees have **30 days** to submit their "briefs" that are a combination of their opening statement and their rebuttal of the member's arguments.
   C. Those briefs are then mailed to the member, Trustees and arbitrator. The member then has **30 days** to submit a rebuttal brief if they choose to do so. This is the member's opportunity to argue against the Trustee's reason why the denial of their claims was appropriate.
   D. The member's rebuttal statement is then sent to the Trustees and the arbitrator. The arbitrator then has **30 days** to render a decision.
   E. The Arbitrator's decision:
      (1) If the arbitrator decides to overturn the denial the Plan will then pay the claims according to the contract.
      (2) If the arbitrator decides to keep the claims denied the member can then move their case to a judicial review (a law suit against the Plan)

On page 58 of the Supplemental Summary Plan Description (SSPD) it states that the "claimant and/or his representative" (not a Plan employee or local officer) may request the appeal process. Any and all correspondence related to the appeal process will be communicated between the Plan, the Trustees, the Arbitrator and the member only.