Medical Certification Program

Our Medical Plan has a certification component to help ensure that you and your family are not receiving unnecessary medical treatment. You'll need to contact the Medical Certification Program vendor—CareAllies—prior to any medical hospital admissions. CareAllies will confirm the necessity of your inpatient hospital stay so that you can receive the highest level of benefits coverage. If you require inpatient psychiatric or substance abuse treatment, you must contact Modern Assistance Programs prior to the hospitalization. See page 27 for more information.

When to Notify CareAllies

You and/or your covered dependents must call CareAllies at 1-800-558-9639 in the following situations:

- If you are going into the hospital, as soon as your admission date has been scheduled;
- If you are admitted to the hospital on an emergency basis, within 24 hours after the admission. (If you are unable to call within 24 hours, call as soon as possible after admission.); and
- If your doctor is planning to admit you to an acute rehabilitation facility or order home health care services.

Headed for the Hospital?

You or your dependent should contact CareAllies by calling 1-800-558-9639 to certify your hospital stay.

What Happens When You Call?

A case associate will ask you for some information about your medical care. Please have this information available when you make the call:

- the member's Social Security or UIN number;
- the patient's name and relationship to you;
- the name of your Fund (Painters & Allied Trades District Council No. 35 Health Fund);
- your doctor's name and telephone number; and
- the name and telephone number of the facility or hospital.

The case associate will assign you a reference number for the inpatient admission. The number is your **guarantee** that you have notified CareAllies. Keep the reference number with your personal files in case you need it in the future.

If You Do Not Call

If you do not contact CareAllies in the situations listed at the left, the Fund will assess you the first $1,000 of hospital expenses incurred during a hospital stay that has not been certified. If CareAllies decides that the hospital or surgical charges were not medically necessary, or were not performed in the appropriate setting, the Fund will not cover any of the services.

Payment of Benefits

Coordination of Benefits

Members of a family are often covered by more than one group health insurance plan. As a result, sometimes two or more plans end up paying for the same expense. To avoid this costly problem, your Health Plan provides a Coordination of Benefits provision.

Coordination of Benefits (COB) is an administrative method that health plans follow that allows you to receive coverage under more than one group insurance plan without receiving duplicate payments for the same expenses. If you and your spouse both work, and you're both covered by each other's group medical plan, COB provides that the provisions of both plans are taken into account when benefits are paid. If you fail to notify the Fund Office of other insurance coverage, you will be required to reimburse the Fund for any claims paid. In addition, overpayments made by the Painters & Allied Trades District Council No. 35 Health Plan will be deducted from future medical claim payments.

The Coordination of Benefits provision applies to your medical, prescription and dental coverage. It does not apply to Life Insurance, Accidental Death and Dismemberment or Supplemental In-Hospital Accident and Sickness Income Benefit coverage. Note: If your dependents have prescription drug benefits through another health care plan, they are not eligible to participate in this Prescription Drug program. However, copayments you pay under the other plan may be submitted to the Fund Office for reimbursement. This includes office visit copayments.

COB applies when you have health care coverage under more than one plan, as defined below. COB rules are used to determine whether this Plan is a primary plan or secondary plan when compared to another plan covering the person. When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced so that payments from all group plans do not exceed 100 percent of the total allowable expense. In no event will the amount of benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved.

If you are eligible for Medicare, this Plan will be coordinated with Medicare Parts A and B whether or not you have enrolled in Part B. This means that if you fail to enroll in Part B, you will be required to pay a larger portion of the bill that would otherwise be payable by Medicare.

Order of Benefit Determination Rules
When two or more plans pay benefits, the first of the following rules that applies determines the order in which the plans pay or provide benefits. The plan that is determined to be the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The secondary plan may consider the benefits paid or provided by another plan in determining its benefits.

Plan Without Model COB:
A plan that does not contain a coordination of benefits provision consistent with the model COB provisions under Massachusetts law is primary.

Nondependent/Dependent:
The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber or retiree) is primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan:
The order of benefits when a child is covered by more than one plan is as follows:

1. if the parents are either married or not separated (whether or not they ever have been married) or if a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage, the primary plan is the plan of the parent whose birthday is earlier in the year or, if both parents have the same birthday, the plan that covered either of the parents longer;

2. if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree; and

3. if the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is as follows: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active/Inactive Employee:
The plan that covers a person as an employee who is neither laid off nor retired is the primary plan. The same rule holds true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage:
If a person whose coverage is provided under a right of continuation provided pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Coverage Period:
The plan that has covered the person as an employee, member, subscriber or retiree longer is primary.

Default Rule:
If the preceding rules do not determine the primary plan, the allowable expenses are shared equally between the plans; however, in no event will this Plan pay more than it would have paid had it been primary.

When this Plan is the secondary plan and its payment is reduced to consider the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the covered individual's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and the others.

Subrogation

You or one of your eligible dependents may incur medical expenses in a situation where a third party —for example, Workers' Compensation or an auto insurance carrier—may be held responsible for their payment. In this case, you must sign a form that permits the Fund to recover all its payments from that third party to the extent that a settlement or judgment makes the third party responsible for payment. In the case of an auto accident, this subrogation will begin when your (or your dependent's) $8,000 PIP* benefits have been exhausted. Until the form is signed, no expenses will be Covered Charges. The Health Plan does not compromise on liens. No medical claims will be considered for payment until the $8,000 PIP benefits have been exhausted and the Subrogation/Lien form is properly executed by all parties. A police report must be submitted if requested, for any accident.

**MedPay in New Hampshire or any state health allowance.*

Maximum Lifetime Benefit

The amount of your Maximum Lifetime Benefit for all covered medical charges combined is $1,000,000. This maximum applies separately to each insured family member. Every January 1, the money you've spent out of your own pocket (up to $1,000 per year) will be added back to your maximum lifetime benefit amount.

Requesting Reinstatement of the Lifetime Maximum

Any time that the Lifetime Maximum of an insured family member is reduced by at least $1,000 because of benefits received, you may request reinstatement of the maximum as long as your dependent is then in good health as may be defined from time to time by the Trustees. You must submit medical evidence of your dependent's good health to the Fund Office. The new maximum becomes effective on the date the Fund Office confirms in writing that the evidence is satisfactory and that the Lifetime Maximum has been reinstated.