

Appeals Procedure

If your claim is denied, in whole or in part, the Welfare Office will provide you with an explanation of benefits which sets forth the reasons for the denial.

If benefits are denied, in whole or in part; if you disagree with a Fund policy, determination or action in whole or in part; if you have a question concerning your claim; or if you have been adversely affected by an action or decision of the Board of Trustees, here is what you (or your representative) should do.

1. Before calling the Welfare Office, review your claim worksheets and medical bills carefully. Make certain that the Fund Office has received all medical bills for your claim. If you still have a question concerning your claim, call (708) 597-1832 and discuss your claim problem with a Claims Representative. The Claims Representative can also refer you to pertinent Plan provisions, a description of any additional material or information which might help your claim, and explain why that information is necessary.
2. If you are still not satisfied or if you have further questions, either talk to the Fund Administrator on the telephone or write a letter explaining your problem. You will be advised in writing of the results of their investigation.
3. If you are still not satisfied with the Administrator's report to you, you may request the Board of Trustees to review your benefit denial or the Fund policy, determination or action with which you disagree, by submitting a written appeal to the Trustees. Your written appeal must be submitted within 180 days of receiving the report of the claims manager of Administrator or within 60 days after you are notified of a Fund policy, determination or action with which you disagree and which is not a benefits denial.

Your appeal should be sent to:

Appeals Committee of the Board of Trustees
Automatic Sprinkler Local 281, U.A., Welfare Fund
11900 South Laramie Avenue
Alsip, Illinois 60803

Your written appeal should state the reason for your appeal. This does not mean that you are required to quote all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Fund policy, determination or action. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The Trustees or a designated committee of the Trustees will review your appeal within 60 days following receipt of your appeal. If special circumstances require a further extension of time for review by the Trustees, you will be notified in writing and a benefit determination will be made no later than 120 days following receipt of your appeal.

You will receive written notice of the decision of the Trustees or designated committee promptly following their review. The notice will include specific references to Plan provisions on which the decision is based, and may indicate if additional information might help your claim.

You may renew your appeal if you have additional information or arguments to present. A renewed appeal must be submitted in writing and the rules and time limits stated above apply.

In connection with an appeal, you may review pertinent documents in the Fund Office after making appropriate arrangements or you may request that documents be provided to you. Under ERISA you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits to use in your appeal.

If you are still dissatisfied after the appeal process, you may bring suit under the Employee Retirement Income Security Act (ERISA), a federal law protecting your welfare benefits.