NAME: **SS#:**

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Safeway	**LOCAL:**	118
DATE OF HIRE:	June 16, 1993	**STATUS:**	Full Time
PLAN:	1		

ISSUE: Hospital/Medical – Excluded Services #M22/102-9299

FUND RULE:
"**General Exclusions**

The expenses listed below are excluded from payment under all benefit categories, for Plan 1, Plan 2 and Plan 3 Participants, unless otherwise stated. […]

34. Telephone consultations with patients or charges for failure to keep a regularly scheduled appointment […]"
(Bakers Union and FELRA Health and Welfare Fund SPD, July 2016, Pages 114-116, #34)

"**Telehealth Services Extension**

In response to the continuing COVID-19 pandemic and recognizing the challenges the pandemic is causing Participants in obtaining medical services and exercising their rights under the plan, the Board of Trustees has extended coverage of Telehealth Services. The Fund will continue to provide coverage for medical services unrelated to COVID-19 provided by a PPO provider by telephone conference or video conference, subject to any applicable Plan limits, rules, and cost-sharing requirements that would apply to an in person visit for the same service. ***Coverage is limited to the period from March 18, 2020 through June 30, 2021*.**"
(Quoted from the Bakers Union and FELRA Health and Welfare Fund "For Your Benefit" newsletter, April 2021, Page 8) (emphasis added)

SUMMARY:

Date(s) of Service:	January 17, 2022
Claim(s) Received:	January 24, 2022
Claim(s) Denied:	January 26, 2022
Appeal Received:	February 9, 2022

The **participant** is appealing for payment of a claim for telehealth services that was denied. The participant states, "At the time of making the doctor's appointment they were only taking appointments for telemedicine video due to the COVID-19 pandemic. I needed to be seen by the doctors, so that was the only appointment that I could get. I honestly did not know that it would not be covered by my insurance."

Fund records indicate that Maryland Primary Care submitted a claim for telehealth services rendered on January 17, 2022 with a primary diagnosis of "Acute recurrent maxillary sinusitis." The claim was denied because the Plan specifically excludes coverage of telehealth services. The Board of Trustees amended the Plan to allow coverage of telehealth services for the temporary period from Mach 18, 2020 through June 30, 2021, only. This claim was incurred after June 30, 2021.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐

COMMENTS:

Claim # BQVW51

February 7. 2022

Employee #
Acct # 104905003?0

Dear Appeals Coordinator,

My name is and I am the policy holder of Cigna healthcare. I wish to file an appeal concerning my visit to Mayland Primary Care on January 17, 2022 that was not covered. At the time of making the doctors appointment they were only taking appointments for Telemedicine video due to the covid 19 pandemic. I needed to be seen by the doctors, so that was the only appointment that I could get. I honestly did not know that it would not be covered by my insurance. Please reconsider my visit at mayland Primary care for January 17, 2022.

Sincerely

RECEIVED
FEB 09 2022
AA, LLC

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

110

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

005742
0101

BAKERS UNION & FELRA H&W

If you have any questions, please call (866) 66-BAKER

Claim #: BQVW51
Statement Date: 01/26/22
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 10490500270
Provider: PRIMARY CARE MARYLAND

Line	Dates of Service	Service Description	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	01/17/22-01/17/22	OFFICE CALL	250.00	250.00	A1 A2	0.00	0.00		0	0.00	0.00	250.00
		TOTALS	250.00	250.00		0.00	0.00				0.00	250.00

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Total Plan Benefit:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check #	Paid Date
MARYLAND PRIMARY CARE PHYS	0.00	NC	01/26/22

Line#	Code	Messages
1	A1	CIGNA HEALTHCARE PREFERRED PROVIDER SAVINGS.
1	A2	THIS SERVICE/SUPPLY IS NOT COVERED BY YOUR PLAN. SPD PG. 116, #34

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Messages** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal or state court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en el resúmen descriptivo del plan.