NOTICE OF ADVERSE BENEFIT DETERMINATION

Date of Notice:
Name of Plan: Labor Alliance Managed Trust Fund
Name of Benefit Administrator: PhysMetrics
Address: P.O. Box 25220 Fresno, CA 93729
Telephone/Fax: (877) 519-8839/(888) 439-4819
Website/Email Address: www.PhysMetrics.com

This document contains important information that you should retain for your records.

This document serves as notice of an **Adverse Benefit Determination**. The Labor Alliance Managed Trust Fund Employee Health Care Plan Benefit Administrator (PhysMetrics) has declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see "Important Information About Your Appeal Rights" for more information).

Case Details:

Patient Name:	**ID Number:**
Address:	
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Description of service:	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:

If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, include that information here. Include: a reference to the specific plan provision(s) on which the determination is based; a description of any additional material or information needed to process the claim, as well as an explanation of why the additional information is needed; information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination, OR a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and that the individual has the right to receive a copy free of charge upon request; if the determination is based on medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, OR a statement that such explanation will be provided free of charge upon request; if a health care professional was consulted, a statement that the reviewer will identify the health care professional whose advice was obtained, whether or not it was relied on, upon the request of the individual.

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Language Assistance Disclosure

SPANISH (Español): Para obtener asistencia en Español, llame al **(877) 519 – 8839**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **(877) 519 – 8839**.

CHINESE (**中文**): **如果需要中文的帮助**，请拨打这个号码 **(877) 519 – 8839**.

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Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at (877) 519-8839 if you need assistance understanding this notice or the decision to deny you a service or coverage. The [*Insert "Employer/Plan" Name*] Employee Health Care Plan "Plan Booklet" also contains detailed information about this claims process.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part). You must file your appeal within 180 calendar days after the date of this notice.

How do I file an appeal? Complete the page entitled "Appeal Filing Form," make a copy, and send this document to: PhysMetrics – P.O. Box 25220 Fresno, CA 93729 See also the "Other resources to help you" section on this page for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal orally by calling PhysMetrics (877) 519-8839, or by following the instructions above for filing an internal appeal. You may also file a simultaneous request for external review with the Department of Health and Human Services orally by calling 1-877-549-8152, or by following the instructions above for filing an internal appeal and by sending the document electronically to disputedclaim@opm.gov, by faxing it to 1-202-606-0036, or by sending it by mail to P.O. Box 791 Washington, D.C. 20044.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. If you want someone to act for you (as your authorized representative) you must submit a completed Designation of Personal Representative naming that person to act for you. You can call us toll free at (877) 519-8839 to request the designation form and learn how to name your representative.

Can I provide additional information about my claim? Yes, you may supply additional information. You may submit written comments, documents, records and other information supporting your claim. The review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit review.
If your appeal is urgent (See "What if my situation is urgent?"), and you send a simultaneous request for external review to the Department of Health and Human Services, any additional information that you provide to the Department of Health and Human Services will be shared with PhysMetrics in order to allow Benefit Administrator a chance to reconsider its denial.

Can I request copies of information relevant to my claim? Yes, you may request reasonable access to, and copies (free of charge) of all documents, records, and other information relevant to your claim. If you think a coding error may have caused this claim to be denied, you have the right to have billing, diagnosis, and treatment codes (and their corresponding meanings) sent to you, as well. You can request copies of this information by contacting us at (877) 519-8839.

When will I be notified of the outcome of my appeal? If you appeal a *pre-service claim*, you will be notified of the outcome of your claim no later than 30 days following the receipt of your request for appeal. If you appeal a *post-service claim*, you will be notified of the outcome of your claim no later than 60 days following the receipt of your request for appeal. If you appeal a *concurrent* care decision you will be notified of the outcome of your appeal as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated. If your appeal is *urgent* your review will be completed within 72 hours. (See "What if my situation is urgent?") If you need help determining whether your claim is a *pre-service*, *post-service*, or *urgent* claim please call PhysMetrics at (877) 519-8839.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by the Department of Health and Human Services, who will review the denial and issue a final decision.

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Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Department of Health and Human Services at the following toll-free number 1-877-549-8152, or the Employee Benefits Security Administration at 1-866-444-EBSA(3272). You can also contact the California Department of Managed Health Care Help Center by calling (888) 466-2291, by mailing questions to 980 9th Street, Suite 500, Sacramento, CA 95814, or by emailing questions to http://www.healthhelp.ca.gov or helpline@dmhc.ca.gov.

Appeal Filing Form

Name Of Person Filing Appeal: _____

Circle one: □Covered person □ Patient □ Authorized Representative

Contact information of person filing appeal (if different from patient)

Address:_____ ____ ____Daytime phone:_____ ___Email:_ _ _____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

X:_____

Are you requesting an urgent appeal? □Yes □ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

Send this form and your denial notice to: PhysMetrics
P.O. Box 25220
Fresno, CA 93729

BE CERTAIN TO KEEP COPIES OF THIS FORM, YOUR DENIAL NOTICE, AND ALL DOCUMENTS AND CORRESPONDENCE RELATED TO THIS CLAIM.