

MEDICAL CLAIM SUBMISSION

The following sets forth the procedure for filing claims for benefits under the AMO Medical Plan.

TIME FOR FILING CLAIMS

Claims for benefits under the AMO Medical Plan must be filed within 365 days following the date the charges are incurred. No plan benefits will be paid for any claim not submitted within this period. Claim forms are available from the AMO Medical Plan office, at various Union offices and via the AMO and AMO Plans web sites.

Generally, inquiries considering the Plan's provisions that are unrelated to any specific benefit claim or are exclusively about eligibility will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. Benefits received from in-network providers and presentation of a prescription to a pharmacy that exercises no discretion on behalf of the Plan are also not considered a claim under these procedures. However, if your request for any of these benefits is denied, in whole or in part, you may file a claim and appeal regarding the denial.

Note: Claims involving **Urgent Care**, as defined below, may be submitted by telephone by calling 1-800-348-6515 or 1-954-920-4247, ext. 13. The phone call must be followed in writing within 24 hours.

WHERE TO FILE YOUR CLAIM

You will not be required to submit a claim form for hospital, medical or prescription drug benefits if you use a provider in one of the Plan's PPO networks, or the Pharmacy Benefit Manager's (PBM) participating pharmacy. In such cases, the provider will submit a claim directly to the AMO Medical Plan. If you do not use an in-network provider, or your claim is for optical, hearing aid, disability benefits, wage insurance, or death benefits or accidental death and dismemberment benefits, you will be required to submit a claim form, together with supporting documentation.

Hospital and Medical Claims

If you use a hospital, doctor, or other type of medical facility that belongs to one of the Plan's PPOs, you generally are not required to file a claim for benefits because the provider will submit the claim directly to the Plan. If you use the services of a hospital, doctor, or other medical facility that does not belong to a PPO, you may be required to submit a claim form, together with an original itemized bill, to the Plan

Optical Claims

A claim form, together with an original itemized bill and supporting documentation specifying the services rendered, must be submitted to the Plan.

Dental (Direct Reimbursement) Claims

An itemized bill is required specifying the dental services rendered and reflecting that all services have been paid in full. **NO BENEFITS WILL BE PAID DIRECTLY TO THE DENTIST OR DENTAL SERVICE PROVIDER.**

Prescription Drug Claims

You do not need claim forms when utilizing a participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of the Plan, it is not considered a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim with the Plan under these procedures. If you do not use a participating pharmacy, a prescription drug claim form, together with the pharmacy bill, must be submitted to the Pharmacy Benefit Manager.

Other Benefits

A claim for other benefits under the AMO Medical Plan, including optical, direct reimbursement dental benefits, disability benefits, death benefits, AD&D benefits, scholarship benefits, wage insurance, and Coast Guard Legal Aid benefits must be submitted to the Plan.