



CLAIMS REVIEW AND APPEAL PROCESS

OSSTF Benefits has worked closely with OTIP to design a made for OSSTF members Benefit plan. The plan provides comprehensive coverage provisions, however, there may be occasions when a claim is partially or wholly denied and you may be unclear, or may disagree, with the reason for the claim denial. To cover these types of situations, an appeal process is built into the OSSTF Benefit plan where you may appeal a claim denial by following the process outlined below:

Step 1 - Clarification and Further Information

OSSTF Benefits encourages members to review the Benefits Booklet for clarification of the provisions of the OSSTF ELHT Benefits Program. The booklet is posted under My Benefits for your access. You can also call into OTIP Benefit Services at 1 866 783 6847 to discuss your claim with an OTIP Benefits Services representative who can assist you in understanding the OSSTF Benefits Plan and why certain benefits may not be covered and/or explain additional information that may be needed to have the claim further reviewed.

If this does not answer your questions or you still disagree with the handling of the claim, you should request that your concerns are escalated to an OTIP Benefits Services Technical Specialist who will investigate the claim, review the plan design, and consult with senior technical staff, the insurance carrier and underwriting as needed, to ensure that the claim is processed correctly.

If these actions do not resolve your concern, you may officially file an appeal. If you are appealing a drug claim that has been declined as part of the FACET prior authorization program you must first file an appeal through FACET and exhaust the FACET appeal process prior to advancing an appeal to OTIP and the OSSTF ELHT.

Step 2 - OTIP Appeal Process

- Appeal requests must be submitted in writing and must outline the reason(s) you believe the claim should be paid. Appeals can be sent:
 - By email to benefitspecialists@otip.com
 - By fax to 1 866 404 6847
 - By mail to:
 - OTIP Health & Dental Appeal Committee, 125 Northfield Dr. W., PO Box 218, Waterloo ON N2J 3Z9
 - The appeal will be reviewed by the OTIP Appeal Committee, who has the authority to approve claims on a one time, without prejudice basis up to a limit of \$5,000 per claim.
 - If you are not satisfied with the decision of the OTIP Appeal Committee, you may ask to move the appeal to the OSSTF ELHT Appeals Committee for their review and decision.

Step 3 – OSSTF ELHT Appeal Committee

- The OTIP Appeal Committee will present the details of your appeal on a confidential anonymous basis to the OSSTF ELHT Appeals Committee for their review and decision. The OSSTF ELHT Appeals Committee may approve the appeal on a one time, without prejudice basis, maintain the denial or refer the appeal to the ELHT Board for a final decision. The ELHT Appeals Committee/Board is the final authority of the Appeal Process.
- The OSSTF ELHT Appeals Committee will report their decision to OTIP and the OTIP Benefits Services Department will communicate the appeal outcome to you.

Note: Appeals must be in writing, the claim must be a minimum value of \$150 and the appeal must be initiated within 90 days of the initial claim decision date for health or dental and within one year of the claim decision date of a life claim. In exceptional cases, the OSSTF ELHT can, in its sole discretion, extend the deadline for the initiation of an Appeal. Such extensions will only be granted where satisfactory reasons exist for the delay (such as medical incapacity) and where no prejudice will result to the OSSTF ELHT by granting the extension. Such extensions will be communicated to all relevant parties, and the decision of the OSSTF ELHT on any extension shall be final.