Level Fund Appeal Language

AHA Self Insured Language

IMPORTANT INFORMATION IF YOU CHOOSE TO APPEAL

We want to help you understand your benefits and the reasons for this determination. Please contact Customer Experience at the number on the back of your plan ID card to discuss your questions and concerns.

If you are dissatisfied with this decision, you, or someone you name to act for you as your authorized representative (designee), including an attorney, have the right to appeal the denial. You or your designee must file the appeal within at least 180 days of receipt of this notice. For information about naming a designee, call Customer Experience at the telephone number listed on the back of your health plan identification card. Further, at any time, you have the opportunity to submit additional written comments, documents, and/or other information pertaining to your claim for the review. At your request, the Plan provides access to, and copies of, all relevant documents, records, and other information at any time to you or your designee *free of charge*.

Full and Fair Review. You or your authorized representative is entitled to a full and fair review. Further, at all levels of internal appeal, you or your authorized representative have the opportunity to submit additional written comments, documents, and/or other information pertaining to your claim for the review. You or your authorized representative may specify the remedy or corrective action being sought. At your request, the Plan provides reasonable access to, and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged at any time to you or your authorized representative free of charge. The Plan will automatically provide you or your authorized representative with any new or additional evidence or new rationale considered, relied upon, or generated by the Plan in connection with the appeal. Such evidence or new rationale is provided as soon as possible and in advance of the date the final internal adverse benefit notification is issued.
For medical necessity issues, should you desire more information about the decision and/or a free copy of the internal guidelines or protocol used to make the decision, please send a written request including the Reference Number found at the top of this letter to “Clinical Rationale” at the address provided below.

To file an appeal of this determination, call, write, or fax a request to:

AmeriHealth Administrators
Appeals Department
PO Box 21545
Eagan, MN 55121
Phone: 1-800-952-3404
Fax: 215-761-0956

If you decide to appeal, the following summary gives you general information about the appeal process.

If you wish to file an appeal, please include the following information with your submission:

- Patient name;
- Member name;
- Address;
- Member ID number;
- Reasons for appealing;
- Any evidence you want us to review, such as medical records, operative reports, doctors' letters (such as a doctor's supporting statement if you request an expedited appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.

THE TWO TYPES OF APPEAL

Medical Necessity/Grievance. An appeal of an adverse decision based upon medical necessity or, decisions that were made based upon identification of treatment as cosmetic or experimental/investigative.

Administrative/Complaint. An appeal regarding an unresolved dispute including contract exclusions/limitations, participating or non-participating healthcare provider status, non-covered services, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions).

At each level of appeal, you or your designee may, at any time, request the aid of a Plan employee in preparing or presenting your appeal *at no charge.* This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file. If you would like assistance in preparing your appeal, please call the number listed above.

INTERNAL APPEALS – STANDARD AND EXPEDITED

Standard Appeals

Medical Necessity

- **Pre-service Appeal.** An appeal for benefits that, under the terms of this Contract, must be pre-certified or preapproved before medical care is obtained in order for coverage to be available.
  - You have one level of Standard Pre-service Internal Appeal that is completed within 30 calendar days of receipt of request.
- **Post-service Appeal**. Post-service is concerning claims that have been received for services that the Covered Person has already obtained.
  - You have one (1) level of standard post-service internal appeal that is completed within 60 calendar days of receipt of request.

Administrative

- You have two (2) levels of Standard Appeal for Administrative. Each level is completed in 30 calendar days of receipt of request for each level of Appeal.

Urgent Care/Expedited Appeals. An Urgent Expedited Appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a physician with knowledge of the

Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

- Your appeal review is completed within 72 hours of the appeal request.

Note: If you believe your situation is urgent, you may request an Expedited External Review. You have the right to file an Expedited External Review at the same time as the Internal Expedited Appeal for urgent and ongoing care. To file an appeal, call, write, or fax a request to the address above.

Under the appeal process in effect for this self-insured plan, your Group Plan Administrator will be responsible for any additional appeals, Expedited Appeal, and any External Review, if applicable. Once the request is received, the Claims Administrator forwards all documents to your Group Plan Administrator. Your Group Plan Administrator advises you or your designee of the decision regarding any applicable subsequent levels of appeal.

INFORMATION ABOUT EXTERNAL REVIEW

You have one (1) level of Standard or Expedited External Review by an Independent Review Organization (IRO). An External Review process is available for any adverse benefit determination that involves medical judgment as determined by the external reviewer and for rescissions of coverage.

Standard External Review. Submit your request by calling the Plan at the number above within 180 days of receipt of the final Internal Appeal decision letter and an Independent Review Organization (IRO) will render a decision within 45 days of request.

Expedited External Review. You have 72 hours from receipt of determination letter to submit an Expedited External Review request by calling the Plan at the number above. Expedited External Review is completed within 72 hours of the request.

The decision of the External Review is binding on the Plan.

For additional information regarding your internal and external appeal rights, please refer to your plan booklet or call Customer Experience.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal you may have the right to bring civil action under Section 502(a) of the Act. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

If your plan fails to "strictly adhere" to the internal appeals process, you may initiate an external review or file appropriate legal action under state law or ERISA unless:

- Violation was *de minimis* (minimal).
- Did not cause (or likely to cause) prejudice or harm to the claimant.
- Was for good cause or due to matters beyond the control of the insurer/plan.
- In the context of a good faith exchange of information with the claimant.
- Not part of a pattern or practice of violations.

To learn more about your appeal process, refer to your Member Handbook or Evidence of Coverage or call the Member Experience Department at the telephone number listed on the back of your health plan identification card.