CLAIMS AND APPEALS

APPEAL PROCEDURES

If a claim is denied in whole or in part, you have the right to file an appeal to have your claim reviewed. You must follow the procedures described in this section to file an appeal.

You will be given an opportunity for a full and fair review by the Plan Administrator, or its delegate, of the decision denying the claim. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, you will be provided either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, you will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

For purposes of deciding appeals, the Carrier responsible for administering the coverage is the delegate of the Plan Administrator. Such delegates have discretionary authority to interpret and apply the Plan on behalf of the Plan. The individual or individuals at the Carrier who decide the appeal will not be the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. The review will not afford deference to the initial adverse benefit determination.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the Carrier will:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Carrier in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and,

- Provide that the health care professional engaged for purposes of the consultation referenced above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

After you receive notice that a claim was denied, in whole or in part, you have 180 days to make a written request to the applicable Carrier to have the claim reviewed. If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as described in the chart. If the review by the Carrier results in an adverse determination, you may initiate a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

If you are in the TCN or PPO, your Carrier provides one level of appeal for claims. If you are not in the TCN or PPO, please consult your Carrier's benefits statement for details about the appeals procedure.

- To initiate review of a denied claim, you or your authorized representative must send the Carrier a written statement explaining why you disagree with their determination. Please include in your request all documentation, records or comments you believe support your position. You must request review no later than 180 calendar days after you receive the claim decision. Mail your written request for review to the address in the letter from the Carrier notifying you that they have not approved a benefit or service you are requesting. The Carrier will provide you with a written determination within the applicable timeframe, unless they have notified you in writing that they need additional information to complete their review.

- If you disagree with the final determination, or if the Carrier fails to issue its determination within the applicable timeframe or otherwise fails to comply with the review procedures, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits.