

## SECTION 14

### CLAIM, COMPLAINT AND APPEAL PROCEDURES

#### Section 14.1 – Pre-Approval or Pre-Service Claims

The Covered Person, his or her Provider, or a designated representative must contact the Review Organization designated for his or her plan at least 48 hours prior to a scheduled inpatient confinement in a hospital or skilled nursing facility, or any non-office based outpatient surgery, at the pre-certification number shown on the Identification Card. If the person is admitted on an emergency or urgent care basis, such notification should be made within the 48 hours following the admission.

Pre-certification is not required for any hospital stay in connection with childbirth, as long as such stay does not exceed 48 hours following a normal delivery, or 96 hours following a delivery by cesarean section.

If the Review Organization is not notified within the time frames listed above, benefits payable on the otherwise covered expenses will be reduced by 20%, up to a maximum of \$5,000.00. In addition, any expenses determined by the Review Organization to not be medically necessary will not be covered under the plan.

The Review Organization may request additional information which is necessary to make the determination from the Covered Person or a Provider. In the case of an urgent care request, such information must be provided within 48 hours of the request. We will notify you of our determination on the urgent care request not later than 24 hours of our receipt of the information necessary to make the determination. If the request does not involve urgent care, the information must be provided within 45 days of such request. An "urgent care" request is one that, if a determination is not made on an expedited basis, the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function, could be seriously jeopardized, or, in the opinion of the attending Physician, the Covered Person would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

#### Section 14.2 - Initial Filing of Claims

All claims for medical services or supplies should be filed in writing as soon as possible after the services are rendered, or the supplies are received. A claim will be accepted by Us for up to one (1) year from the date the claim was incurred.

Claims should be submitted to the appropriate address listed on the Identification Card, and can be submitted either by the Provider or the Covered Person. Such claim should be on any of the following appropriate forms (or their successor forms):

1. CMS 1500;
2. UB-04 or UB-92;
3. HCFA-1450 or CMS 1450;
4. NCPDP Form 1983; or
5. J512 claim forms.

In addition, such claim can be submitted on any approved Medical Benefits Mutual Life Insurance Co. form, at the claimant/provider's discretion.

A claim can be submitted by the Provider in electronic format if the Provider submits it in accordance with the electronic transaction requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Such claims must use most current CPT code in effect as published by the American Medical Association, the most current ICD-9 code in effect as published by the US Department of Health and Human Services, the most current dental code in effect as published by the American Dental Association in the *Code for Dental Procedures or Nomenclature* or the most current HCPCS code in effect, as published by US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

In addition, the following information must be attached to the claim, if appropriate:

1. If the Our plan is not the primary carrier for a person who has, or had at the time the claim was incurred, more than one health plan which would provide benefits for the services or supplies for which the claim is being made, including, but not limited to Medicare, copies of the explanations of benefit payment from all carriers who would pay benefits before Us. If you do not know whether or not We are the primary carrier on the claims, refer to the Coordination of Benefits section in this certificate, or contact Our Customer Service Department at 800-423-3151.
2. If the claim involves dental services, any dated pre-operative x-rays and other clinical documentation which were produced in the course of the treatment which may be necessary to make a determination on a particular service.

#### Section 14.3 - Requests for Additional Information

If the claim is not submitted in accordance with the above procedures, the Covered Person will be notified of the claim deficiencies, and requested to refile it in the proper format.

If no additional information is needed to process the claim, We will pay or deny the claim within 30 days after We receive it. We will notify both the You and Your provider of our determination. If denied, the notice will state why we denied the claim.

If We need more information to process the claim, a letter will be sent to the Covered Person, the Provider or other parties requesting additional information. In some situations, information is needed on a periodic basis, including:

1. verification of active employment status from the Covered Person's employer, for employees 65 years of age and older;
2. information regarding other coverage. This may include providing copies of medical child support orders for children of divorced parents; and
3. verification of support status for Dependent children; and
4. verification of handicapped status for dependent children who are older than the Dependent age limits.

Other information may be requested on a case-by-case basis, including accident details or potential third-party liability.

In addition, if the claimant is age nineteen (19) or older and the claims are incurred within the first year of the individual's coverage, medical records may be requested to determine if the claims are related to any Preexisting Condition. Such investigation may not be necessary if the individual provides Us with documentation of at least one year of prior Creditable

Coverage. For information about pre-existing condition restrictions or what coverage may be considered as creditable coverage, see the plan certificate, or contact Our Customer Service Department.

The requested information must be provided within 45 days of the date the Covered Person receives notice of the required additional information. If the information is not received within this time period, the Covered Person will be notified that the claim is denied for failure to provide the needed information.

The claim will be paid or denied within 45 days of our receipt of the claim. However, any time between when We requested any additional information and our receipt of this information will not be counted towards the total 45 day period, unless we make an additional request for information after receiving Your response to our initial request and the request does not involve a possible Pre-Existing Condition that we were unaware of as of the date of the initial request.

#### Section 14.4 - Initial Grievance Procedures

If a Covered Person has questions about any actions taken by Us in regards to claims or other matters, or needs information regarding his or her grievance/appeal rights in connection with the insurance coverage, Our Customer Service Department is available from 9:00 a.m. CST to 6:00 p.m. CST to provide assistance at the telephone numbers listed below.

If a Covered Person is not satisfied with the results of a Our determination of any of the types described below, the claimant or his or her authorized representative can file a grievance with Us:

1. a determination that a service or proposed service is not appropriate or medically necessary;
2. a determination that a service or proposed service is experimental or investigative;
3. the availability of participating providers;
4. the handling or payment of claims for health care services; or
5. a matter relating to the contractual relationship between:
  6. the Covered Person and Us; or
  7. the Plan Sponsor and Us.

Any individual other than the Covered who wishes to submit a grievance on the Covered Person's behalf must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the grievance. An assignment of benefits is not sufficient to designate another person as an "authorized representative" for the purpose of grievances. These procedures shall not apply to any contractual dispute between a Provider and Us as to amounts due the Provider, rather than the Covered Person, under the terms of any agreement between the provider and Us which does not affect the amount payable by the claimant (i.e. balance billing issues in a preferred provider contract).

If a grievance involves an "urgent care" situation, as described in the section entitled "Appeals of Grievance Determinations" below, it will be handled in accordance with the appeals procedures for expedited appeal, rather than under the provisions of this section.

An initial grievance can be filed orally or in writing to the following:

**Medical Benefits Mutual Life Insurance Co.**  
**P.O. Box 1009**  
**Newark, Ohio 43058-1009**  
**Telephone: (740) 522-8425**  
**Toll Free Number: 1-800-423-3151**  
**Fax: (740) 522-5002**

The Covered Person (or his or her authorized designee) should clearly state at the time the grievance is filed that it is intended to be a formal grievance in accordance with these procedures.

Section 14.5 - Appeals of Adverse Benefit Determinations

The Covered Person or individual can appeal a decision by Us that coverage for a service or supply is denied or reduced under the policy, or any other eligibility issue, including a rescission of coverage for an individual, provided such appeal is made in writing within 180 days of the person's receipt of Our explanation of benefit payment, the precertification letter reflecting the denial or reduction or any other notification made by Us of an adverse decision involving the individual. Any individual other than the Covered Person who wishes to submit an appeal on the Covered Person's behalf must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the appeal. An assignment of benefits is not sufficient to designate another person as an "authorized representative" for the purpose of appeals. These appeal procedures shall not apply to any contractual dispute between a Provider and Us as to amounts due the Provider, rather than the Covered Person, under the terms of any agreement between the Provider and Us which does not affect the amount payable by the claimant (i.e. balance billing issues in a preferred provider contract).

A request for review in which the Covered Person is requesting an expedited appeal of a pre-service claim as an "urgent care" case, as described in Section 14.1, can be submitted either orally or in writing and can be submitted by a Provider with knowledge of the claimant's condition without prior designation by the Covered Person. If a course of treatment has been previously approved by us to be provided over a period of time or for a number of treatments, no reduction or termination of coverage for such treatment (other than termination of the individual's coverage under this Plan) will be made without allowing the Covered Person sufficient advance notification and the opportunity to appeal this termination or reduction.

The appeal request should be addressed to the following:

**Appeals Committee**  
**Medical Benefits Mutual Life Insurance Co.**  
**P.O. Box 1009**  
**Newark, Ohio 43058-1009**

A Covered Person should submit with the appeal written comments, documents, records and other information relating to the claim for benefits, even if such information was not submitted as part of the initial claim or request for preauthorization. The Covered Person may also submit testimony and other evidence as part of the appeal process. The Covered Person may also submit testimony and other evidence as part of the appeal process.

The claimant has the right to request information from MedBen as part of the appeals process, as described below in Section 14.6.

#### Section 14.5 - Independent Review Rights and Procedures

If the Covered Person does not agree with Our determination on appeal in regards to a procedure which has been proposed by a health care Provider, such Covered Person may be entitled to an independent review of any of the following issues by an independent review organization:

1. appropriateness;
2. medical necessity; or
3. the experimental or investigative status of a proposed service.

All internal appeal/grievance rights listed above must be exhausted before such review can be requested. Only one independent review can be requested as a result of any grievance. A request for independent review must be submitted in writing within 45 days after the claimant receives notification from Us of the disposition of the claimant's appeal.

A request for independent review may be made to Us by the Covered Person or an individual who has been authorized in writing by the claimant specifically to handle his or her independent review. The claimant can utilize the assistance of other individuals, such as health care providers, attorneys, friends and family members through the review process. An expedited review can be requested if processing the review within the time frame for a standard review would seriously jeopardize the claimant's :

1. life or health; or
2. ability to reach and maintain maximum function.

The Covered Person may be required to pay a fee of up to \$25.00 to cover the costs associated with the independent review. All other costs will be paid by Us.

The Covered Person is required to cooperate with the independent review organization by providing any requested information and authorizing the release of any necessary medical information.

The Covered Person is permitted to submit additional information relating to the proposed service throughout the review process. At that time, We may decide to reconsider the proposed service, and the independent review process will halt while the reconsideration is made. If the Covered Person is not satisfied with the result of the reconsideration, he or she may request that the independent review process be resumed.

#### Section 14.6 - Access to Documents, Records or Other Information

The claimant is entitled to receive, upon request and free of charge, reasonable access to documents, records and other information relevant to his or her claim for benefits, including any new or additional information received during the appeals process and the rationale behind our adverse decision. Such information is considered to be relevant if it was relied upon by MedBen in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, demonstrates compliance with the administrative processes required by ERISA, constitutes a statement of policy or guidance with respect to the plan concerning the denial of a treatment option or benefit, or involves the identity of medical or vocational experts whose advice was obtained in connection with the claim.

In addition, if an adverse benefit determination is based upon the medical necessity or experimental nature of the service or supply, the claimant can request an explanation of the scientific or clinical judgment of the determination, free of charge.

Section 14.7 - Additional Appeal Rights

If, after the Covered Person has exhausted all appeal and review rights listed above, he or she is still not satisfied with the disposition of the claim, such Covered Person has the right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA) (if the employer sponsoring this plan is subject to ERISA). Such action must be brought within three years of the date the claim was required to be filed.

This amendment takes effect on the later of the first Plan Year on or after September 23, 2010, the date the Plan is determined to be non-grandfathered, as defined in the Patient Protection and Affordable Care Act, or the effective date of the Plan to which it is attached. This amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.



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Douglas J. Freeman  
President