

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us orally or in writing to request an appeal. **Call the telephone number shown on your ID card.** Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your appeal to us in writing, the representative can provide you with the address.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

How to Appeal all other Complaint/Grievance Decisions

If you disagree with either any complaint/grievance determination other than those described under *How Do You Appeal a Claim Decision?* above, you can contact us orally or in writing to formally request an appeal. Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your appeal to us in writing, the representative can provide you with the address.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The reason you disagree with the determination.
- Any documentation or other written information to support your request.

Your first appeal request must be submitted to us within 180 days after you receive our decision on your complaint/grievance.

Appeal Process

We will respond to oral and written appeals of complaint/grievance decisions by providing written or oral acknowledgement of the appeal not more than five business days after the appeal is filed.

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits, Post-service Claim and any other Complaint/Grievance Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims and any other complaint/grievance as defined above, the appeal will take place and you will be notified of the decision within 45 days from receipt of a request for appeal.

Please note that our decision for pre-service requests for Benefits and post-services claims are based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights are described under the *External Review* provision in your Certificate of Coverage and will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.