

# **YOUR CLAIM PROCESSING and APPEAL RIGHTS**

[Self-Funded Group Health Plan]

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan established by your employer. As a Plan participant, you [and your covered dependent(s)] have certain claim processing and appeal rights under the Employee Retirement Income Security Act of 1974 (as amended) (ERISA).

## **1. Introduction**

**Notice:** These procedures are furnished as a separate document that accompanies the Summary Plan Description (SPD) for your Plan. Consult the SPD for details regarding the benefits provided under the Plan.

**Purpose:** Under ERISA and applicable U.S. Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. This Notice is intended to comply with ERISA and DOL regulations by providing reasonable procedures governing the filing of benefit claims, the issuing of benefit decisions and the appeal of adverse benefit determinations.

## **2. Definitions**

**Plan:** The Plan is the Employee Welfare Benefit Plan established by your employer.

**Claim:** A claim is any request for Plan benefits made in accordance with these procedures. Any communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

**Claimant:** You become a claimant when you make a request for Plan benefits in accordance with these procedures.

**Incorrectly-Filed Claim:** Any request for benefits that is not made in accordance with these procedures is called an incorrectly-filed claim.

**Authorized Representative:** An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized until the Plan receives written authorization signed by the claimant. Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding determinations, unless the claimant provides specific written direction otherwise. *Any reference in these procedures to claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.*

**Plan Sponsor/Plan Administrator/Plan Fiduciary/Plan Trustee:** Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. The Plan is self-insured by your employer and benefits are funded by employer and employee contributions. The Plan is not insured by an insurance company and your employer is solely responsible for all benefit payments. Your employer, in its capacity as the Plan Administrator and in light of the purposes for which the Plan was established and is maintained, shall consider and render, in its sole discretion, appropriate eligibility, coverage and benefit determinations. In particular, your employer shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the Plan. Your employer is also responsible for making claim and appeal determinations.

**Designated Administrator:** Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). As the designated administrator, Allied National is authorized to process enrollments, bill and collect contributions, process claims payments, and perform other services, according to the terms of the agreement.

## **3. How to File a Claim for Benefits**

**General Filing Rules:** A claim for benefits is made when a claimant (or authorized representative) submits written Notice and Proof of Loss as required in the SPD to: **Allied National, LLC, Attn: HealthCare Management, PO Box 29186, Shawnee Mission, KS 66201; or fax at 913-945-4390.**

A claim will be treated as received by the Plan: (a) on the date it is hand delivered to the above address; (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address (the postmark on any such envelope will be proof of date of mailing); (c) on the next business day immediately following the date it is faxed using the above fax number; or (d) on the next business day immediately following the date it is electronically submitted in compliance with HIPAA electronic transaction standards.

Notice of a claim shall be filed within 30 calendar days, and Proof of Loss of a claim shall be filed within 90 calendar days, following receipt of the medical service, treatment or product to which the claim relates. However, if it was not reasonably possible to file notice or proof within those time periods, notice must be filed within 90 calendar days, and Proof of Loss must be filed within six (6) months, following receipt of the medical service, treatment or product (except in the case of legal incapacity of the claimant).

**How Incorrectly-Filed Claims Are Treated:** These procedures do not apply to any request for benefits that is not made in accordance with these procedures.

#### **4. Determining Benefits**

**Timeframe:** The Plan shall determine benefits for a claim, or request any additional information needed to process an incomplete claim, within a reasonable time, but no later than 30 calendar days after receipt of the claim. The Plan issues only retrospective (post-service) claim determinations.

**When Extensions of Time Are Permitted:** Nothing prevents the claimant from voluntarily agreeing to extend the above timeframes.

**Incomplete Claims:** If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

**How Incomplete Claims Are Treated:** If a claim is incomplete, the Plan may deny the claim or request the missing information within the 30-calendar day timeframe described above. If the Plan requests the missing information, it shall do so in writing and include a description of the missing information. The missing information must be provided within 45 calendar days. If the missing information is provided, the Plan shall determine benefits within 15 calendar days of receipt. If the missing information is not provided within the 45 calendar days, benefits may be denied or the claim may be inactivated.

#### **5. Notification of Adverse Determination by Plan**

**Written Notification:** Written notification of an adverse determination by the Plan shall be provided to the claimant.

**Content of Notification of Adverse Benefit Decision:** Written notification provided to the claimant of the Plan's adverse determination on a claim shall include the following, in a manner calculated to be understood by the claimant:

- a statement of the specific reason(s) for the determination;
- reference(s) to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to complete the required proof of loss and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the determination; and
- if the determination involves scientific or clinical judgment, an explanation and discussion of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances.

**Definition of Adverse:** A determination on a claim is "adverse" if it is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

#### **6. Your Right to Appeal**

**Your Right to Appeal:** A claimant has a right to appeal any adverse determination (for both coverage and benefit determinations) and to receive a full and fair review under these procedures (Claim Review).

**Claim Reviews:** Please follow the instructions below to request Internal and External Claim Reviews for adverse determinations. You may also contact Allied National's Customer Service Department at **1-800-825-7531** with any questions about Internal and External Claim Reviews.

#### **7. How to Request INTERNAL Claim Review for an Adverse Benefit Determination**

If you disagree with a coverage or benefit determination, you have the **RIGHT TO APPEAL** that adverse determination by requesting an Internal Claim Review within **180 CALENDAR DAYS** from the date you received the coverage or benefit determination. Only one (1) Internal Claim Review is available per claim. An Internal Claim Review determination acts as a Final Internal Adverse Benefit Determination.

##### **Internal Claim Review Instructions and Procedures:**

- A. To request an Internal Claim Review, please:
  - i. State your request for an Internal Claim Review in writing, include your full name, date of birth and certificate number, identify the claim in question, and explain why you disagree with the determination. You also may submit any additional written comments, documents, records or other information relating to the claim.
  - ii. Sign and date your written request and attach all supporting documentation.
  - iii. Mail the written request and attachments to the following address, **within the 180-day deadline stated above:**  
**Allied National, LLC, Attn: HealthCare Management, PO Box 29186, Shawnee Mission, KS 66201**

- B. Upon request and at no charge, you may have reasonable access (including copies) to the claim file, including all documents, records and information submitted to our office that relate to your claim.
- C. The Internal Claim Review will take into account all written comments, documents, records and other information submitted to our office that relate to your claim, including comments, documents, records or other information not previously considered or submitted at the time the claim was processed.
- D. Copies of any clinical rationale or review criteria and any new or additional evidence which the Internal Claim Review considers, relies upon or generates will be included with our written determination, free of charge.
- E. The Internal Claim Review will be a “fresh” look at your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination, not currently supervised by someone involved in that determination, and whose terms of employment are not based on the likelihood of upholding that determination.
- F. If the appealed determination is based on a medical judgment (in whole or in part), the Internal Claim Review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination, not currently supervised by someone involved in that determination and whose terms of employment are not based on the likelihood of upholding that determination.
- G. You, your doctor or your authorized representative may request an Internal Claim Review and you may be represented by a relative, friend, lawyer or other authorized representative.
- H. You may present evidence and testimony by submitting written comments, documents, records or other information relating to the claim. Hearings, panel reviews or other formal in-person proceedings are not conducted.
- I. Within 5 business days of receiving your written request, our office will mail a written acknowledgement to you.
- J. Within 30 calendar days of receiving your written request, our office will mail a written determination to you.

## **8. How to Request a *Second* Internal Claim Review (Optional)**

**Optional Second Internal Review Instructions and Procedures:** If you disagree with the Internal Claim Review, you may go directly to External Review (if available, see below) or you may request an optional Second Internal Review. A written request for a Second Internal Review must be submitted to our office within 180 CALENDAR DAYS [six (6) months] from the date you received the determination for the initial Internal Claim Review. Please refer to the Internal Claim Review Instructions and Procedures stated above for completing and submitting a written request for a Second Internal Review. Only one (1) Second Internal Review is available per claim. A Second Internal Review is completely voluntary and not required to exhaust your rights of appeal under your health plan coverage.

## **9. How to Request *EXTERNAL* Claim Review for an Adverse Benefit Determination**

**External Review:** You may have a right to External Review of your claim if:

- A. You disagree with the Internal Claim Review (or the optional Second Internal Review, if one was requested); and
- B. Your claim is eligible for Independent or External Review by an Independent Review Organization (IRO) under applicable law (including, but not limited to, medical judgment determinations such as medical necessity, appropriateness, health care setting, level of care or effectiveness).

Only one (1) External Review is available per adverse determination. External Review is provided at no charge to you (some states may charge a small processing fee) and acts as a Final External Review Decision.

**External Review Instructions and Procedures:** If External Review is available for your claim, an application packet will be enclosed with the determination for the Internal Claim Review. To request External Review, please follow the instructions contained in the packet and mail the application within 120 CALENDAR DAYS [four (4) months] from the date you received the determination for the Internal Claim Review (or the Second Internal Review, if one was requested).

## **10. How to Request DOL & Plan Assistance**

**DOL Assistance:** You have the right to request assistance from, or to file a complaint with, the U.S. Department of Labor (DOL) at any time. Please note the following DOL contact information: **U.S. Department of Labor, Attn: ERISA Claim Appeals, Employee Benefits Security Administration (EBSA), 200 Constitution Ave NW, Washington, DC 20210; or 1-866-4-USA-DOL (1-866-487-2365); or [www.dol.gov/general/contact](http://www.dol.gov/general/contact).**

**Plan Assistance:** To request assistance from or to file a complaint with the Plan, please note the following contact information: **Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201; or 1-800-825-7531; or [www.alliednational.com](http://www.alliednational.com).**

## **11. How to Request Federal Court Assistance**

**Judicial Review:** If you exhaust all of your Internal and External Review rights under your Self-Funded Group Health Plan, you have the right to bring a civil action under Section 502(a) of ERISA. The time limitations stated in your SPD for bringing legal actions apply to any such civil action. Please consult an attorney for more information.