YOUR RIGHT TO APPEAL

A Covered Person has a right to appeal an adverse benefit determination, including a rescission, under these claims' procedures.

1. **How to File An Appeal.** If a Claimant disagrees with an adverse benefit determination, the Claimant (or authorized representative) may appeal the decision within 180 days from receipt of the adverse benefit determination. With the exception of urgent care claims, the appeal must be made in writing, should list the reasons why the Claimant does not agree with the adverse benefit determination, and must be sent to the address given for the University of Utah Health Plans Appeals and Grievances Department. If the Claimant (or authorized representative) is appealing an urgent care claim, the Claimant may appeal the claim verbally by calling the telephone number listed for urgent care appeals listed on the inside cover of this Policy.

   The Claimant may ask for Request for Review forms which may be obtained by contacting the University of Utah Health Plans, Appeals Committee Chairperson, 6053 Fashion Square Dr., Suite 110, Murray, UT 84107. A Request for Review form or a written appeal will be treated as received by the University of Utah Health Plans Appeals and Grievances Department (a) on the date it is hand-delivered to the above address and room; or (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 the date of mailing. Written appeals must be sent to the University of Utah Health Plans Appeals and Grievances Department following address shown on page 5. The Claimant has the right to contact the Office of the Montana State Auditor, Commissioner of Securities and Insurance (CSI), for assistance with an appeal. They can be reached at 840 Helena Ave, Helena, MT 59601, (406) 444-2040.

2. **Access to Documents.** The Claimant will, on request and free of charge, be given reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit determination, the names of each such expert will be provided on request by the Claimant, regardless of whether the advice was relied on by Us.

3. **Submission of Comments.** A Claimant has the right to submit documents, written comments, or other information in support of an appeal.

4. **Important Appeal Deadline.** The appeal of an adverse benefit determination must be filed within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision to reduce or terminate an

initially approved course of treatment (see the definition of concurrent care decision) must be filed within 180 days of the Claimant's receipt of the notification of the decision to reduce or terminate. Failure to comply with this important deadline may cause a Claimant to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

5. **Urgent Care Appeals.** In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the University of Utah Health Plans Appeals and Grievances Department by mail, telephone or electronically; refer to page 5, *Important Information*, for contact information. The claim should include at least the following information:

   a. The identity of the Claimant;

   b. A specific medical condition or symptom;

   c. A specific treatment, service, or product for which approval or payment is requested; and

   d. Any reasons why the appeal should be processed on a more expedited basis.

   e. If a physician with knowledge of the Claimant's medical condition determines the claim involves urgent care, We will treat the claim as an urgent care claim.

   f. If an urgent care claim is incomplete or was not properly submitted, We will notify the Claimant, or Claimant's authorized representative about the incomplete or improper submission no later than twenty-four (24) hours from Our receipt of the claim. Our notification will contain a reference to a specific Covered Person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which approval is being requested. The Claimant will have at least forty-eight (48) hours to provide the necessary information. We will notify the Claimant of the initial claim determination no later than twenty-four (24) hours after the earlier of the dates We receive the specific information requested or the due date for the requested information.

   g. Requests for an extension of a previously approved time period for treatments or number of treatments, and if the Claimant's claim involves urgent care, We will review the claim and notify the Claimant of Our determination no later than twenty-four (24) hours from the date We received the Claimant's claim, provided the Claimant's claim was filed at least twenty-four (24) hours prior to the end of the approved time period or number of treatments.

6. **Evidence Consideration.** The review of the claim on appeal will take into account all evidence, testimony, new and additional records, documents or other information the Claimant submitted relating to the claim, without regard to whether such information was submitted or considered in making the initial adverse benefit determination.

   If the University of Utah Health Plans Grievances and Appeals Department considers, relies on or generates new or additional evidence in connection with its review of the claim, it will provide the Claimant with the new or additional evidence free of charge as soon as possible and with sufficient time to respond before a final determination is required to be provided by the University of Utah Health Plans Grievances and Appeals Department. If the University of Utah Health Plans Grievances and Appeals Department relies on new or additional reasons in denying the Claimant's claim on review, the University of Utah Health Plans Appeals and

Grievances Department will provide the Claimant with the new or additional reasons as soon as possible and with sufficient time to respond before a final determination is required to be provided by the University of Utah Health Plans Appeals and Grievances Department.

7. **Scope of Review.** The independent and impartial person who reviews and decides the Claimant's appeal will be a different individual than the person who decided the initial adverse benefit determination and will not be a subordinate of the person who made the initial adverse benefit determination. The review on appeal will not give deference to the initial adverse benefit determination and will be made anew. The University of Utah Health Plans Appeals and Grievances Department will not make any decision regarding hiring, compensation, termination, promotion or other similar matters with respect to the individual selected to conduct the review on appeal based upon how the individual will decide the appeal.

8. **Medical Professionals.** In the event that a claim is denied on the grounds of medical judgment, the University of Utah Health Plans Appeals and Grievances Department will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same person who was consulted, if any, regarding the initial benefit determination or a subordinate of that person.