

Your Right to Appeal

Your Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.
2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.
3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal Claims and appeals process.
4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.
5. Upon request and at no cost, the Claimant will receive access to relevant claim documents, information on rules or guidelines used, available voluntary appeals, external review rights, and the clinical or scientific basis for the determination.
6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.
7. No deference will be afforded to the previous Adverse Benefit Determination.
8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.
9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the DDM or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.
10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.
11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of the DDM and will be decided within thirty (30) days of the Plan's receipt of the request.

For questions about appeal rights or for assistance, Claimants can contact the Employee Benefits Security Administration at 866-444-EBSA (866-444-3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for Claim appeals is available.