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. The appeal may be made in writing or over the telephone. Written appeals should list the reasons the Claimant does not agree with the adverse benefit determination, may include additional medical documentation and must be sent to the address given for the U of U Health Plans Appeals and Grievances Department. If the Claimant (or authorized representative) is appealing over the telephone, the Claimant should call the telephone number listed on the inside cover of this Policy.

   The Claimant may ask for Request for Review forms which may be obtained by contacting the U of U Health Plans Appeals and Grievances Department or on our website at www.mhc.coop/idaho under Forms. A Request for Review form or a written appeal will be treated as received by the U of U Health Plans Appeals and Grievances Department on the date it is delivered to the above address and room. Written appeals must be sent to the U of U Health Plans Appeals and Grievances Department address shown on page 5.

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. 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 Treatment Care Appeals.** In light of the expedited timeframes for decision of urgent care claims, an urgent care appeal may be submitted to the U of U Health Plans Appeals and Grievances Department by mail or telephone; 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.

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 U of U 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 U of U Health Plans Grievances and Appeals Department. If the U of U Health Plans Grievances and Appeals Department relies on new or additional reasons in denying the Claimant's claim on review, the U of U 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 U of U Health Plans Appeals and Grievances Department.

7. **Scope of Review.** The 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 U of U 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 U of U 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.