

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.¹

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [INSERT ADDRESS OF WHERE APPEALS SHOULD BE SENT TO THE HEALTH CARRIER] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing. Once our internal appeal process is exhausted (or waived by us), you may be entitled to file a request for external review.³

External Review³: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you request by submitting a request for external review within **4 months** after receipt of this notice to the Oklahoma Insurance Department, which can be contacted by mail at 400 NE 50th Street, Oklahoma City, OK, 73105, or by phone at 800-522-0071 or 405-521-2828. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would

seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.¹

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).