Alliance Coal Health Plan

# Appeal Request Form

If you are not satisfied with the initial attempt to resolve your problem or if you wish to request a review of a benefit determination, preauthorization decision, or a rescission of coverage, you must request an appeal within 180 days from the date you received notice of the adverse benefit determination, explanation of payment/benefits, or preauthorization notice.

As a part of the appeals process, you have the right to be provided, upon request and free of charge, reasonable access to or copies of all documents, records, and other information relevant to the claim. The appeal process will include 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.

Please complete all fields. Incomplete forms received will be rejected. Mail or fax completed form and any pertinent documentation, including additional medical records to:

**Alliance Coal Health Plan**
**Attn: Appeals**
**PO Box 1950**
**Tulsa, OK 74101-1950**
**FAX: 844-230-8727**

| | | |
|---|---|---|
| Today's Date: | Patient (or Member) Name:<br><br>Patient's DOB: | Patient's Member ID number (ACZ#): |
| Name of Appeal Requestor: | Appeal Requestor's relationship to member (circle one):<br>member/spouse/parent/provider | Appeal Requestor's Phone #:<br><br>Appeal Requestor's Fax: |
| Claim number (if applicable): | Date of Service: | Place of Service (Provider's name): |
| Service or Procedures Received (if applicable): | | |
| Use this space (and attach additional sheets if necessary) to explain why the claim denial decision should be reversed. If you are requesting a Plan exception because the service is excluded from coverage, explain why you feel it should be covered and what treatment has been tried, dates they were tried, and the date and reason why they were discontinued. You should also attach **related** medical records (MD's office visit notes, x-ray results, lab results, etc.). | | |

Alliance Coal Health Plan

# Claim Appeals Procedure

The Medical Plan has established the following process to review any dissatisfactions, complaints, and appeals. If you have designated an authorized representative, that person may act on your behalf in the appeals process.

## Questions and Complaints

If you have a question or complaint that does not directly relate to a claim for benefits, you can **contact Member Services at (855) 979-5192**. For questions or complaints regarding on-site Health Center services, contact the Health Center staff. The resolution of these questions or complaints is not officially considered an appeal. If you have a question or complaint about a claim for benefits, an initial attempt should be made to resolve the problem by directly communicating with Member Services at (855) 979-5192. In most cases, Member Services can provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through the appeal process described below. You must use the internal appeal and external appeal processes below before seeking a review of your claim in court. You may request to review information used to make any adverse determination. Copies will be provided free of charge.

## Internal Appeal

- **How and When to File an Appeal**

If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of a benefit determination, preauthorization decision, or a certain type of retroactive termination of coverage (a "rescission"), you must request an appeal within 180 days from the date you received notice of the adverse benefit determination or preauthorization notice. A provider can also submit an appeal of an adverse benefit determination or preauthorization decision on your behalf.

- **How to File an Appeal of a Preauthorization Request Involving an Unscheduled Inpatient Admission**

If you wish to appeal a preauthorization decision involving an unscheduled inpatient admission, you may appeal by calling Member Services at (855) 979-5192. You may also submit such an appeal in writing to the address described below.

- **How to File an Appeal of Claim Denial or a Preauthorization Request Involving Scheduled, Nonemergency Care**

If you wish to appeal a claim denial or a preauthorization decision involving scheduled, nonemergency care, you must submit your request in writing to the following address:

**Alliance Coal, LLC**
**Attn: Plan Administrator**
**PO Box 1950**
**Tulsa, OK 74101-1950**

You have the option of using the Health Plan Appeal Request Form to submit your request. Whether you use this form or not, the written request should include your name and identification number, the patient's name, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are dates and places of services, names of providers of services, place of hospitalization, and types of services or procedures received (if applicable). You should include any documentation, including medical records that you want to become a part of the review file. The Plan Administrator may request further information if necessary.

As part of the appeal process, you have the right to be provided, upon request and free of charge, reasonable access to or copies of all documents, records, and other information relevant to the claim. The appeal process 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.

- **The Internal Appeal Process**

Appeals are reviewed by the Plan Administrator. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental or investigational, or not medically necessary or appropriate, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. You have the right to know the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan Administrator in connection with an adverse benefit determination. If the Plan Administrator (i) considers, relies upon, or generates any new or additional evidence in connection with the claim, or (ii) intends to issue a final appeal decision based on a new or additional rationale, such evidence or rationale, as applicable, must be provided to you as soon as possible and sufficiently in advance of the date on

which a final appeal decision is required to be made, to give you a reasonable opportunity to respond prior to that date. It may happen that new or additional evidence is received by the Plan Administrator so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond. If that occurs, the period for providing a notice of the final appeal decision will be extended until you have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to do so, the Plan Administrator will notify you of the appeal determination as soon as reasonably possible under the circumstances.

- **Timing for Decisions on Internal Appeals**

The Plan Administrator will provide you a written decision on your appeal as follows:

- *Unscheduled inpatient admission preauthorization request:* In the case of an appeal of a preauthorization request involving an unscheduled inpatient admission, the Plan Administrator will respond to you no later than 72 hours after receipt of your appeal request at the phone number or address listed above.
- *Nonemergency preauthorization request:* In the case of an appeal of a preauthorization request involving scheduled, nonemergency care, the Plan Administrator will provide a written response to you no later than 30 days following the date that your appeal is received at the address above.
- *All other claims:* In the case of an appeal involving a claim other than a preauthorization request, the Plan Administrator will provide a written response to you no later than 60 days following the date your appeal is received at the address above.

- **Adverse Decisions on Internal Appeals**

If your appeal is denied, then you will generally receive the following information about the denial of the appeal:

- The specific reason(s) for the denial or decision, including the denial code and its corresponding meaning, the standard, if any, that was used in denying the claim, and a discussion of how that standard was applied to any appeal denial.
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- Specific reference to the Plan provision(s) on which the denial or decision was based.
- A statement that you may have access to or copies of all documents or records that are relevant to your claim (without charge).
- A description of the voluntary appeal (if applicable) and external appeal procedures offered by the Plan and a statement of your right to bring a court action under section 502(a) of ERISA.
- If an internal rule, guideline, protocol, or other similar criterion ("criterion"), or any new or additional information, was relied upon in making the denial, either the:
  - Specific criterion and new or additional information used, or
  - A statement that such criterion or information was relied upon in making the benefit denial and that a copy of such criterion will be provided free of charge upon request.
- If the benefit denial is based on medical necessity or experimental or investigational treatment limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the person's special medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

## Voluntary Appeal Process (Generally for Claims That Do Not Involve Medical Judgment)

For certain types of claims, the Medical Plan provides for a voluntary appeal. The term “voluntary” means that, unlike the internal appeal described above; the Plan Administrator cannot claim that you failed to exhaust the administrative remedies available to you for failing to submit the benefit dispute to the Plan Administrator's voluntary appeal process. A voluntary appeal is only available for non-urgent claims that are not eligible for the external appeal process described below. This means that a voluntary appeal is generally only available for non-urgent claims that do not involve medical judgment or a retroactive termination of coverage. For a more specific description of what constitutes a medical judgment for this purpose, please refer to the “External Appeal Process” section below. The following describes the Plan's procedure for voluntary appeal of certain denied claims.

After exhaustion of the internal appeal process outlined above, you may submit an eligible non-urgent benefit dispute to the Plan Administrator for reconsideration.

The Plan Administrator will not charge you any fees or costs as a part of the voluntary appeal process. If you elect to pursue your voluntary appeal rights, any statute of limitations or other defense based on timeliness will be tolled during the time that any voluntary review is pending.

To request voluntary appeal of your benefit determination, you should submit your request in writing within 180 days of the date your appeal was denied to the following address:

**Alliance Coal, LLC**
**Attn: Plan Administrator**
**PO Box 1950**
**Tulsa, OK 74101-1950**

The written request should include your name, identification number, patient name, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are dates and places of services, names of providers of services, place of hospitalization, and types of services or procedures received (if applicable). You should include any documentation, including medical records that you want to become a part of the review file. The Plan Administrator may request further information if necessary.

You have the right to receive, upon request, enough information relating to the voluntary level of appeal to allow you to decide whether to submit your benefit dispute to the voluntary level of appeal. The information you receive should include:

- A statement that your decision will have no effect on your rights to any other benefits under the Plan; and
- Details of the applicable rules, your right to representation, the process for selecting the decision-maker, and the circumstances, if any, that may affect the impartiality of the decision-maker (such as any financial or personal interests in the result or any past or present relationship with any party to the review process).

If your voluntary appeal is denied, you will receive a written explanation of the denial within 60 days following the date your appeal is received. The explanation will include the same type of information included in an internal appeal response (described above).

## Effect of Appeal Decision

Decisions on appeals will be made at the sole discretion of the Plan Administrator and will be final and binding on all persons. You must properly file a claim for benefits and request an internal appeal of any complete or partial claim denial before seeking a review of your benefit claim in court. A court may require you to complete the external appeal process (if available) before hearing your claim. A decision on an internal appeal of a claim denial or a voluntary appeal (if applicable) will be the final decision of the Plan. After the final decision is made by the Plan, you may seek an external appeal (if available) or judicial remedies in accordance with your rights under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). Any claim in court for benefits must be filed no later than 12 months after the date of the final decision on your appeal under the Plan, or the date of an external appeal decision, if later.

## Conflicts of Interest

Each stage of claim decisions, internal appeals, and voluntary appeals will be decided by a person or committee who is not subordinate to (does not "report to") the previous decision-maker. The employment terms, including compensation, of a person involved in a claim decision may not be based on the likelihood that a denial will be supported.

## Additional Assistance

You may also contact the Employee Benefit Security Administration at (866) 444-3272 for assistance.

## External Appeal Process

The Medical Plan and the Prescription Drug Plan also provide an opportunity to request an external appeal of certain claim denials that have been upheld during the internal appeal process. The external appeal is performed by an independent review organization (IRO). You must exhaust the internal claim and appeal process (other than the voluntary level appeal) before commencing an external appeal (except as provided in the section below titled “Expedited External Appeal”).

Currently, external appeal is only available for:

- A claim denial that involves medical judgment, which includes, but is not limited to, those based on one or more of the following (as determined by the external reviewer):
  - The Medical Plan or Prescription Drug Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit
  - The determination that a treatment is experimental or investigational.
  - The determination of whether a member is entitled to a reasonable alternative standard for a reward under a wellness program (if applicable).
  - The determination of whether the Plan is complying with the nonquantitative treatment limitation provisions of the federal mental health parity rules.
- Rescission (retroactive termination) of coverage (whether or not the rescission has any effect on any particular benefit at that time).

For claims that do not satisfy the requirements for an external appeal, the Medical Plan provides for a voluntary appeal. The following sections “Standard External Appeal” and “Expedited External Appeal" describe the Plan's procedures for external appeal of certain denied claims.

## Standard External Appeal

This section sets forth the procedures for a standard external appeal under the Medical Plan and the Prescription Drug Plan (the "Plan"). A standard external appeal is an external appeal that is not considered expedited (as described below under "Expedited External Appeal").

### Request for External Appeal

A claimant (or his or her authorized representative) may request an external appeal if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination following the exhaustion of the internal appeals process for the Medical Plan or the Prescription Drug Plan, as applicable (an "appealable internal claim denial"). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

A request for an external appeal of either a Medical Plan claim or a Prescription Drug Plan claim should be sent to:

**Alliance Coal, LLC**
**Attn: Plan Administrator**
**PO Box 1950**
**Tulsa, OK 74101-1950**

### Preliminary Review

Within five business days following the date of receipt of the external appeal request, the Plan Administrator will complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The appealable internal claim denial does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- The claimant has exhausted the Plan's internal appeal process (or is not required to exhaust the internal appeals process); and
- The claimant has provided all the information and forms required to process an external appeal.

Within one business day after completion of the preliminary review, the Plan Administrator will issue a notification in writing to the claimant. If the request is complete but not eligible for external appeal, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA [3272]). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan Administrator will allow a claimant to perfect the request for external appeal within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

### Referral to Independent Review Organization

The Plan Administrator will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external appeal. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. Within five business days after the date of assignment of the IRO, the Plan Administrator will provide to the assigned IRO the documents and any information considered in making the appealable internal claim denial, including any information considered by the Plan Administrator in a voluntary appeal process.

### Determination by Independent Review Organization

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external appeal. This notice will include a statement that the claimant may submit in writing to the assigned IRO. This must be received within 10 business days following the date of receipt of the notice with additional information that the IRO must consider when conducting the external appeal. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the claimant, the assigned IRO will within one business day forward the information to the Plan Administrator. Upon receipt of any such information, the Plan Administrator may reconsider its appealable internal claim denial that is the subject of the external appeal. Reconsideration by the Plan Administrator will not delay the external appeal. The external appeal may be terminated as a result of the reconsideration only if the Plan Administrator decides, upon completion of its reconsideration, to reverse its appealable internal claim denial and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator will provide written notice of its decision to the claimant and the assigned IRO.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan's claims administrator, the Plan Administrator, claimant, or the claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate..

The assigned IRO will provide written notice of the final external appeal decision within 45 days after the IRO receives the request for the external appeal. The IRO will deliver the notice of final external appeal decision to the claimant and the Plan Administrator.

The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external appeal, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external appeal and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

### Reversal of Plan's decision

Upon receipt of a notice of a final external appeal decision reversing the appealable internal claim denial, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim (in the amount determined under the terms of the Plan).

## Expedited External Appeal

### Request for Expedited External Appeal

A claimant may request an expedited external appeal at the time the claimant receives:

- An appealable internal claim denial if the denial involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- An appealable internal claim denial, if the claimant has a medical condition where the timeframe for completion of a standard external appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the appealable internal claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

A request for an expedited external appeal of either a Medical Plan claim or a Prescription Drug Plan claim should be sent to:

**Alliance Coal, LLC**
**Attn: Plan Administrator**
**PO Box 1950**
**Tulsa, OK 74101-1950**

### Preliminary Review

Immediately upon receipt of the request for expedited external appeal, the Plan Administrator will determine whether the request meets the reviewability requirements set forth above under "Standard External Appeal." The Plan Administrator will immediately send a notice that meets the requirements set forth above under "Standard External Appeal" to the claimant of its eligibility determination.

### Referral to Independent Review Organization

Upon a determination that a request is eligible for external appeal following the preliminary review, the Plan Administrator will assign an IRO pursuant to the requirements set forth above for a standard external appeal. The plan will provide or transmit all necessary documents and information considered in making the appealable internal claim denial to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for a standard external appeal. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

### Notice of Final External Appeal Decision

The assigned IRO will provide notice of the final external appeal decision, in accordance with the requirements set forth above for a standard external appeal, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external appeal. If that notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.