SECTION 7. GRIEVANCE AND APPEALS

This section outlines the procedures for and the time periods applicable to grievances and appeals. The Insured, the Insured's authorized representative, or Physician or health care provider has the right to file a Grievance, file an appeal, and have an External review. It is the policy of this Company to provide Insureds with a full and fair review of grievance and appeal decisions.

Contact Member Services
A Grievance can be provided to us verbally or in writing in any form, by the Insured or on behalf of the Insured. Contact our Member Services team at [833-600-1311, TTY: 586-693-1214] or by email to [apcsupport@ascension.org] if there is a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage. Written complaints or Grievances can also be mailed to us at US Health and Life Insurance Company, [PO Box 1707, Troy, MI 48099-1707].

We will send an acknowledgement letter upon our receipt of your grievance.

An appeal is a request to reconsider a decision about your benefits where either a service or claim has been denied. This includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of healthcare service or benefits, including the admission to, or continued stay in, a healthcare facility. Failure to approve or deny a prior authorization request in a timely manner may be considered as a denial and subject to the appeal process. Rescissions and certain determinations that involve whether we complied with the surprise billing requirements and cost-protections of the No Surprises Act.

To file an appeal, you can mail or email your request to us at:

US Health and Life Insurance Company
[PO Box 1707
Troy, MI 48099-1707
apcsupport@ascension.org]

Definitions
For the purposes of this section, the following terms and their definitions apply:

Grievance: A written appeal of an adverse determination or final adverse determination submitted by or on behalf of an Insured regarding: availability, delivery or quality of health care services regarding an adverse determination; claims payment, handling or reimbursement for health care services; matters pertaining to the contractual relationship between the Insured and the Company; or matters pertaining to the contractual relationship between the Insured, us and the Physician or health care provider.

Adverse Determination: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; and any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.).

External Review: A process, independent of all affected parties, to determine if a health care service is Medically Necessary and Medically Appropriate, experimental/investigational. Independent review typically (but not always) occurs after all appeal mechanisms available within the health benefits plan have been exhausted. Independent review can be voluntary or mandated by law.

Independent Review Organization: An independent review organization (IRO) acts as a third-party medical review resource which provides objective, unbiased medical determinations that support effective

decision making, based only on medical evidence. IROs deliver conflict-free decisions that help clinical and claims management professionals better allocate healthcare resources.

Life Threatening: A disease or condition for which the likelihood of death is probable unless the course if the disease or condition is interrupted.

Same/Similar Specialist Review: Review by a health care practitioner who has appropriate training and experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems or sufficient for the specialist to determine if the service or procedure is Medically Necessary or clinically appropriate.

Adverse Determination Appeal Process

Process of Appeals of Prospective, Concurrent and Retrospective Adverse Determinations

If you disagree with our decision, you, your representative or provider may submit an appeal either verbally, in writing, or in person at the Plan's physical location. Verbal filings will be treated as appeals to establish the earliest filing date. If the appeal is made orally, you or your representative are informed of the importance of returning the Appeal Form and any additional information you would like to submit to be considered in the review before a decision on their appeal is made

Timeline to file an appeal:
Preservice: 180 days from date of receipt of the Adverse Benefit Determination Notice
Post Service: 180 days from date of receipt of the Adverse Benefit Determination Notice

There are four types of appeals:

- Standard Appeal/Post Service: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- Expedited Appeal: An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits. An expedited appeal is also available for a denied step therapy protocol exception request.
- Specialty Appeal: This appeal is available only after we decide the initial appeal. Your health care provider can request a particular type of specialty provider review the case, the appeal or the decision denying the appeal must be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. Your provider must request the appeal no later than 10 working days after the date the appeal is denied. We will complete the review within 15 working days of receipt of the request.
- Acquired Brain Injury Appeal: An appeal concerning an acquired brain injury.

We will provide a letter of acknowledgement of the appeal within five (5) working days from our receipt of the appeal. This letter will include: acknowledgement of the date we received the appeal; a list of relevant documents needed to be submitted to us; and an appeal form to be completed if the appeal was received by us orally for review of the appeal.

The Adverse Determination Appeal Process includes the following:

1. Appeal decisions are made by a clinical associate or Physician who has not previously reviewed the case.

2. The Physician or provider involved in the appeal review is a practitioner in the Same or Similar Specialty that typically treats the medical condition, performs the procedure or provides the treatment as well as treating similar complications of those conditions. Depending on the type of case, a Same or Similar Specialist may be a Physician, behavioral healthcare practitioner, chiropractor, Dentist, physical therapist or other type of practitioner as appropriate. Their training and experience will be

sufficient for the specialist to determine if the services or procedure is Medically Necessary or clinically appropriate, to include having training to treat the condition and treating complications that may result from the service or procedure. In cases where we do not have a Medical Director that is a Same or Similar Specialty, the case is referred to a contracted Same or Similar Specialist. We will include a list of titles and qualifications, including specialties, of individuals participating in the appeal review.

3. If the appeal decision involves medical necessity or appropriateness, or the experimental or investigational nature of the health care services prior to issuance of an adverse determination, your provider will be offered a reasonable opportunity to discuss the plan of treatment for your care with the physician reviewing your case. The discussion at a minimum includes the clinical basis for the decision.

Specialties include, but are not limited to:		
• Cardiology	• Neurology	• Pediatrics
• Chiropractic	• Neurosurgery	• Podiatry
• Dermatology	• OB/GYN	• Psychiatry
• Emergency Medicine	• Oncology	• Pulmonology
• Family Practice	• Ophthalmology	• Radiology
• Gastroenterology	• Orthopedics	• Surgery
• Internal Medicine	• Otolaryngology	• Urology

4. The physician or provider performing the appeal review will attest that he/she is licensed or certified in a field that typically manages the clinical issue under review and has current and relevant knowledge and/or experience to render a determination for the case that he/she is reviewing on appeal.

5. The Physician or provider reviewing the appeal may interview the Insured or the Insured's designated representative.

6. Provide an opportunity for the Insured and his or her representative to examine the Insured's case file, including medical records, other documents and records, and any new or additional evidence considered during the appeal process. This information will be provided free of charge and sufficiently in advance of the resolution time frame for appeals.

7. If the appeal decision involves Medical Necessity or appropriateness, or the Experimental or Investigational nature of the health care services prior to issuance of an Adverse Determination, we will offer the provider of record a reasonable opportunity to discuss the plan of treatment for the Insured with our Medical Director. The discussion at a minimum includes the clinical basis for the decision.

Expedited Appeal Process

The expedited appeal process includes denial for emergency care, Life Threatening conditions, continued stays for hospitalizations, denial of prescription drugs or intravenous infusions for which the patient is receiving benefits and an expedited appeal for a denied step therapy protocol exception request.

An expedited appeal is reviewed by a health care provider who has not previously reviewed the case and who is of the Same or Similar Specialty as typically manages the medical condition, procedure, or treatment under review.

Expedited appeals are completed based on the medical immediacy of the condition, procedure, or treatment and will not exceed one working day from the date all information necessary to complete the

appeal has been received. You will receive a response by telephone or electronic transmission and will be followed by a letter within three working days of the initial telephonic or electronic notification.

Resolution Letters for Adverse Determination or Expedited Appeals

Upon determination of the appeal we will issue a letter to the Insured, the Insured's authorized representative, or the Insured's Physician or health care provider of record explaining the resolution of the appeal. This letter will include the following:

- A statement of the specific medical or contractual reasons for the resolution;
- The clinical basis for the decision;
- A description of or the source of the screening criteria that were used in making the determination
- The professional specialty of the physician who made the determination
- Notice of the appealing party's right to seek review of the adverse determination by an external review and the procedures for obtaining that review.
- A copy of the form to request an external review
- Procedures for filing a complaint related to utilization review process

Standard/Post Service: Written notification to the appealing party of the determination of the appeal will be completed as soon as practical, but in no case later than 30 days after the date we received the written appeal or the one-page appeal form.

Expedited Appeals: An expedited appeal determination may be provided to the appealing party by telephone or electronic transmission and shall be followed with a letter within three working days of the initial telephonic or electronic notification.

In a circumstance involving an Insured's Life Threatening condition, denials of prescription drugs and intravenous infusions that are currently being received, or if our internal appeal process timelines are not met, the Insured is entitled to an immediate appeal to an external review and is not required to comply with procedures for an internal review of the Adverse Determination.

Timeline for Resolution
Preservice Urgent: No later than 1 working day from the date all necessary information has been received
Preservice (non-urgent): 15 days
Post-Service: 30 days

External Review of Adverse Determination Process

If you disagree with our decision about your appeal and the decision involved medical judgment, then you have the right to ask for an external review by an independent third party. You, a person acting on your behalf, an attorney, or your provider can ask for an external review within 4 months of getting the appeal decision. If you file an appeal or ask for an external review, we will not hold it against you, or your provider.

How to request an external review
Maximus Federal Services, Inc. is the independent review organization that will conduct the external review. You can use forms from Maximus to ask for an external review or send a written request, including any additional information for review. You can get the Maximus forms by calling Member Services, Maximus at 1-888-866-6205 ext. 3326 or online at https://externalappeal.cms.gov.

Fill out one or both of the Maximus forms based on who will ask for the external review. Complete:

- The HHS-Administered Federal External Review Request Form to request an external review yourself.
- Both the HHS-Administered Federal External Review Request Form and the Appointment of Representative Form if you want your child's provider or another person to ask for the external review for you.

- Both you and your authorized representative need to complete this form.

Or, send a written request with:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Signature of member, parent or legal guardian, or authorized representative
- A short description of the reason you disagree with our decision

Send your forms or written request to us at:

Company: Seton Health Plan dba: Dell Children's Health Plan
Address: [1345 Philomena St., Suite #305]
[Austin, TX 78723]
Phone: [1-844-995-1145 (TTY: 586-693-1214)]
Fax: [512-380-7507]
Email: [SHP-Authorization@ascension.org]

You can also send your request directly to Maximus by one of the ways below:

Online:
https://externalappeal.cms.gov. - Use "Request a Review Online" tab

Mail:
HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Ave., Suite 705
Pittsford, NY 14534

Fax: 1-888-866-6190

If you send additional information to Maximus for the review, it will be shared with Seton Health Plan dba: Dell Children's Health Plan so that we can reconsider the denial. If you have questions during the external review process, contact Maximus at [1-888-866-6205, ext. 3326] or go to https://externalappeal.cms.gov

You can ask for an expedited external review:

- If you asked for an expedited appeal after our initial denial and waiting up to 72 hours would seriously jeopardize your child's life, health or ability to regain maximum function, you can request an expedited external review at the same time
- When waiting up to 45 calendar days for a standard external review would seriously jeopardize your child's life, health or ability to regain maximum function
- If the appeal decision is about an admission, availability of care, continued stay, or health-care service for which emergency services were received but the member has not been discharged from the facility

How to request an expedited external review:

- online: you can select "expedited" when submitting the review request; or
- email: [FERP@maximus.com]; or
- call: Federal External Review Process at [1-888-866-6205 ext. 3326]

We will accept the external reviewer's decision related to the medical necessity, appropriateness or experimental or investigational nature of health care services for you. We will be responsible for paying any charges for the external review.

If you, your authorized representative, or provider has any questions regarding the appeal process, please contact us at [1-844-995-1145 (TTY: 586-693-1214)].

Right to a Judicial Review

You have the right to bring suit (including under ERISA Section 502(a) if applicable) in state or federal court (as appropriate) only after exhausting the Appeal of an Adverse Decision, whether or not an external review was pursued. However, in the case of an Adverse Decision eligible for external review involving a Life-Threatening condition, no appeal is necessary and only completion of the external review process is required in order for the right to bring suit to accrue. In all events, such suit or proceeding must be commenced no later than 5 years after the date from the time written proof of loss is required to be given.

Strict Adherence by the Plan

If for any reason the Plan fails to strictly adhere to these appeal procedures as required by state or federal law, the Insured shall be deemed to have exhausted the internal claims and appeals process regardless of whether the Plan asserts it substantially complied with appeals procedures or committed any de minimis error

NOTICE

Questions regarding your policy or coverage should be directed to:

US Health and Life Insurance Company [1-800-211-1534]

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance [Consumer Services Division
311 WEST Washington Street,
Suite 300 Indianapolis, IN 46204]

[Consumer Hotline: (800) 622-4461; (317) 232-2395]
Complaints can be filed electronically at [www.in.gov/idoi].