APPEAL RIGHTS AND INFORMATION

As a Community Health Options (Health Options) Member, you have the right to request an Appeal if you disagree with an adverse determination (denial). You must request an Appeal (Level I or Level II) within 180 calendar days of the date on the notification of a denial decision. You, your representative, or your health care provider may Appeal the adverse determination.

Please submit your Medical or Benefit Appeal requests in writing to:

Appeals Coordinator
Community Health Options
Mail Stop 800
PO Box 1121
Lewiston, ME 04243
Fax: 877-314-5693

You may call Health Options' Member Services at 1-855-624-6463 for information and assistance with filing an Appeal or requesting an External Review of an adverse Appeal decision. Member Services is also able to assist you if you have any special cultural needs or require translation services.

Reconsideration Requests (Medical Necessity Denials ONLY):

When a requested service is denied for medical necessity by Health Options through the Prior Approval process, your provider may request a reconsideration of the denial by calling Health Options' Medical Management Department at 855-542-0880. Through the reconsideration process, the provider may discuss the request with a physician reviewer and may present additional clinical information in order to determine if medical necessity criteria have been met. If the reconsideration results in approval of the requested service(s), you will receive an approval letter from Health Options. If the reconsideration upholds this denial, your provider will be notified in writing. After a reconsideration or absence of a reconsideration, you still have the right to the appeals process as stated below.

LEVEL I: Standard and Expedited Appeals:

Standard Appeal Process:
Your Appeal request must include your name, your Health Options member identification number from the front of your Membership ID card, identifying information regarding the denial being appealed (any applicable claim numbers, dates of service, provider names) and any information to support your request for an Appeal. You may submit additional written comments, clinical documentation, records or other relative information supporting the Appeal request. You have the right, before and during the Appeal process, to obtain a copy and/or examine the case file. Prior to issuing a final adverse determination, we will provide you, free of charge, any new or additional evidence considered, relied upon, or generated by Health Options (or at our direction) in connection with the claim and will provide such evidence as soon as possible and sufficiently in advance of the decision, to give you a reasonable opportunity to respond. You have the opportunity to review the claim file and present evidence and testimony as part of the internal appeals process.

Health Options will send an acknowledgement letter within three (3) working days of receipt of your Appeal request. For Standard Appeals, we will process your Appeal as fast as possible, but no later than 30 calendar days of receipt of the request. Written Notification will be sent to you and your provider. In the event that the standard Appeal decision upholds the adverse determination, you have the right to request a Level II Appeal or, if applicable, an External Review if the denial concerns an adverse health care treatment decision. See section below on External Appeals for more information.

Upon receiving your Appeal, Health Options assigns it to a reviewer. The reviewer conducting the Appeal will not have been involved in the original denial decision and will not be a subordinate of the reviewer who made the original denial. The reviewer must conduct a full investigation, including consideration of all information submitted. If it is determined with the review that the original adverse determination did not supply the Member with all relevant information, such evidence will be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.

The reviewer may uphold or overturn the original denial decision. If the reviewer overturns the initial denial, Health Options will implement the decision of the reviewer as soon as possible. Appeals that concern denials due to lack of medical necessity are conducted by a clinical peer that is a physician or other licensed health care practitioner who holds a non-restricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type or cost of the medical condition, procedure or treatment that the physician or other licensed health care practitioner approves or denies on behalf of a carrier who is in a similar medical specialty as typically manages the medical condition, procedure, or treatment as deemed appropriate.

Expedited (fast) Appeal Process: You may be eligible for an expedited Appeal if your Appeal involves services that, if delayed, could seriously jeopardize your health or your ability to regain maximum function. You should work with your provider to request an expedited Appeal. We will grant an expedited review of any Appeal for services concerning (1) an Inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has Medical Emergency Services and has not been discharged from the Hospital where Medical Emergency Services were provided. A verbal request for an expedited Appeal can be made by calling Health Options' Medical Management at 1-855-542-0880. Within 24 hours of receiving the request for the Appeal, or on the first business day following after-hours or weekend requests, Health Options will notify your provider of all information required to evaluate the Appeal and render a decision. You or your provider will be notified of the Appeal decision by Community Health Options as expeditiously as the medical condition requires, but no later than 72 hours after the request is received. The Appeal decision is given to the Member and/or the provider telephonically on the day of decision. Written notification is sent to the provider and the Member within two (2) working days of the Appeal decision. In the event that the expedited Appeal decision upholds the adverse determination, you have the right to request a Level II Appeal (Maine Plans only*) or, if applicable, an External Review if the denial concerns an adverse health care treatment decision. An External Review may be filed at the same time as an expedited Level I Appeal, if applicable. See below section on External Reviews for more information

LEVEL II Appeals: Must be filed within 180 days of Level I denial. If an adverse benefit determination is upheld (Appeal denied) at the Level I Appeal, you, your representative, or your provider may request a Level II Appeal. Submit a request for a Level II Appeal in writing to Health Options using the Health Options address listed above. You may also call Health Options' Member Services at 1-855-624-6463 for help submitting the Appeal. Members enrolled in individual Plans may bypass the Level II Appeal and request an external review if the Appeal concerns an adverse health care treatment decision. See below for more information about External Reviews.

For Level II Appeals, Health Options will appoint a panel of people who were not involved in the initial denial or Level I Appeal decision to review the appeal and render a decision. You or your representative have a right to: attend the hearing in person or by telephone; present the case before the panel; submit supporting information before and during the Appeal; ask questions of the panel; be assisted by a representative; and obtain information, including the medical file related to the Appeal, free of charge (including criteria for appeal decision and/or any additional evidence submitted).

Prior to issuing a final adverse determination, we will provide you, free of charge, any new or additional evidence considered, relied upon, or generated by Health Options, (or at our direction) in connection with the claim and will provide such evidence as soon as possible and sufficiently in advance of the decision, to give you a reasonable opportunity to respond. You have the opportunity to review the claim file and present evidence and testimony as part of the internal appeals process.

The panel will make a determination on a Level II Appeal within 45 calendar days of receipt of the request if you attend the hearing. The panel will make a determination on a Level II Appeal within 30 calendar days of receipt of the request if you do not attend the hearing. If you request to attend the Level II hearing, you will be given notice of the hearing 15 calendar days in advance of the hearing date. Health Options will not unreasonably deny a request for postponement of the review. The Level II Appeal decision letter is sent to you and your provider within five (5) business days of the Appeal decision. If the Level II Appeal concerns a medical necessity denial, the panel will include a minimum of one clinical peer.

Additional Information for Concurrent Review Appeal of Previously Approved Services:
In cases where an Appeal is filed for a current course of treatment coverage, the care will be continued as long as all of the following criteria are met:
• The Appeal was filed in a timely fashion;
• The Appeal involved the termination, suspension, or reduction of a previously authorized course of treatment;
• The services were ordered by an authorized provider; and
• The original period covered by the authorization has not expired.

Requests for Non-Formulary Exception-to-Coverage Drugs
If a Non-Formulary Exception-to Coverage request is denied, Members may request that an independent review organization (IRO) review the exception request and denial of that request. If the exception-to-coverage request was standard in nature, the IRO must make a determination within 72 hours. If the exception-to-coverage request was expedited, the IRO must make a determination within 24 hours.

Requests for an External Review (also called an External Appeal):
If you are not satisfied with the Appeal decision you may request an External Review if the following applies to you:

- Members enrolled in an Individual Plan may request an External Review only after a Level I Appeal request has been exhausted.
- Members enrolled in a Group Plan may only request an External Review after both a Level I and Level II Appeal request have been exhausted.

External Reviews apply to adverse health care treatment decisions. An adverse health care treatment decision means a decision regarding diagnosis, care, or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

You must send your request for an External Review to the appropriate Insurance Department in your state. Please find the address below.

Insurance Departments contract with independent organizations called External Review Organizations (ERO) to conduct a medical review of your case. When you file an External Review your case is assigned to an ERO. EROs have appropriate health experts to review your case. The ERO ensures that the health professional has no conflicting relationship with your insurance company.

You must apply for the External Review within 12 months of the last adverse decision. You will not be required to pay for an External Review.

The Insurance Department will provide you with all the information you need regarding the External Review process. You must provide the Insurance Department with contact information if you want to participate in the telephone hearing. You can include yourself, your health care provider, and also a particular representative from the insurance company to participate if you like. You will need to provide the ERO with a signed authorization and a copy of the last adverse decision you received from Health Options. Health Options will send the information from your Appeals file to the ERO and a copy of those file records to you. You will have an opportunity to submit additional materials that you would like the ERO to consider when reviewing your case. The ERO is required to complete the review within 30 days after it receives the case. The ERO will send you a written decision within a week after the hearing. If the ERO decision is in your favor, Health Options must comply. All decisions rendered by the ERO are final and binding.

Members are not required to exhaust Health Options' internal Appeals process before filing for external review if:

• Health Options fails to make a decision within the required timeframes or has not adhered to all requirements stated herein;
• The Member applies for expedited external review at the same time as an expedited internal review;
• Health Options and the Member mutually agree to bypass all internal reviews;
• The life or health of the Member is in serious jeopardy;
• The Member is deceased; or
• The adverse health care treatment decision concerns an admission, availability of care, a continued stay or health care services after receipt of emergency services and the Member has not been discharged.

You have a right to request assistance from Community Health Options; attend the external review; submit and obtain supporting material relating to the adverse healthcare treatment decision under review; ask questions of any representative of the carrier; and have outside assistance.

To request an External Review, call or write to the Bureau of Insurance at:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Phone: 1-800-300-5000
TTY: 1-888-577-6690
Web site at: www.maine.gov/pfr/insurance

You also have the right to file a complaint with the Bureau of Insurance at any time using the applicable address and phone number provided above.