FRESNO UNIFIED SCHOOL DISTRICT

EMPLOYEE HEALTH CARE PLAN

PLAN BOOKLET

APPEALS SECTION

Page numbers referenced in this document reflect page numbers in the Plan Booklet

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

The information in this section applies to the following benefit providers who have contracted to provide services under the Fresno Unified School District Employees Health Plan (the "Plan"):

Anthem Blue Cross Network Provider
Avante Health Mental Health and Substance Abuse Program
ChiroMetrics Chiropractic Plan
Claremont Employee Assistance Plan
EnvisionRx Options Prescription Drug Plan
Delta Dental Plan
Vision Service Plan

If you participate in the Kaiser Permanente Plan, Pacific Union Dental Plan, the Safeguard Vision Plan, the Standard Life Insurance Plan, and/or the Prudential Accidental Death & Disability Plan, and a claim for benefits is denied you must follow the appeals procedures of that plan. Only that plan is able to extend or modify any time limits set forth in that plan's appeal procedures. If you do not agree with the result obtained under the insured plan's procedure you may make a written request to the JHMB (the Joint Health Management Board of Fresno Unified School District) to intervene. If the JHMB determines that the position of the Participant is correct, the JHMB shall contact the insured plan and request that the plan change its decision. The JHMB, however, is limited to this role. The insurer is the ultimate decision maker for these plans.

FILING A CLAIM

NOTICE OF CLAIM
The Plan does not generally require Participants or Dependents to file any claim forms as long as:

- Itemized claims are submitted by the provider directly to the Claims Administrator.
- Payment is assigned to the provider of service.

If your provider does not submit the claim on your behalf (for example, if you are billed directly by an Out-of-Network provider), written notice of a claim must be given to the appropriate Claim Administrator within the timeframe noted in the chart below. Any claim for services not submitted within the timeframe indicated below will be ineligible for payment unless a written appeal is approved by the Joint Health Management Board, which approval must be based on proof of special circumstances which made timely filing of the claim unfeasible.

PROVIDER ADDRESS AND TIMETABLE FOR SUBMISSION OF CLAIMS

Claims Administrator and Address	Claims Must be Submitted within Months of Date Incurred Noted Below
Anthem Blue Cross Network Provider Grievances and Appeals P.O. Box 54159 Los Angeles, California 90054	12 months
Avante Health Mental Health and Substance Abuse Program 1111 E. Herndon Ave, Suite 308 Fresno, California 93720	12 months
ChiroMetrics Chiropractic Plan 4678 N. First Street Fresno, California 93726	90 Days
Claremont Employee Assistance Plan Claims Department Claremont Behavioral Services 1050 Marina Village Parkway, Suite 203 Alameda, California 94501	12 months
Delta Dental Plan Delta Dental of California P.O. Box 997330 Sacramento, California 95899-7330	12 months
Delta Health Systems Appeals Department P.O. Box 1931 Stockton, California 95201	12 months
EnvisionRx Options Prescription Drug Plan Attn: Clinical Services/Appeals 2181 E. Aurora Road Twinsburg, Ohio 44087	12 months
Vision Service Plan VSP Appeals P.O. Box 2350 Rancho Cordova, California 95741	12 months

EXTENSION OF COVERAGE DUE TO DISABILITY

You or your authorized representative WILL need to submit claims for an extension of coverage based on Disability to the District's Benefit Department, in writing, using the appropriate claims form (see page 70 of this Plan Booklet for more information regarding extensions of coverage based on Disability). Disability claims should be submitted within 60 days of the date on which the employee's or dependent's coverage will end.

RESCISSION OF ELIGIBILITY FOR COVERAGE

You will have 30 calendar days from the date you receive notice of a rescission of coverage to file an appeal with the District's Benefit Department.

USING AN AUTHORIZED REPRESENTATIVE
An authorized representative, such as your Spouse, may complete a claim or receive claim information for you if you previously designated the individual to be your authorized representative (you can obtain a form from the District's Benefit Department or the Benefits Administrator). Additional information may be required from you to verify that this person is authorized to act on your behalf.

In the case of an urgent care claim, a Physician with knowledge of your condition may act on your behalf even without written authorization.

INTERNAL CLAIMS PROCEDURES

TYPES OF CLAIMS FOR BENEFITS
For the purposes of these Claims Review Procedures, "claim for benefits" means a request for benefits under the Plan. This term includes, *pre-service claims*, *urgent care claims*, *concurrent care claims*, *post-service claims*, *disability claims*, and an appeal from a *rescission of coverage*.

Pre-service claims: A pre-service claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained (also called "prior authorization"). These are the types of claims that will generally be submitted by your Provider.

Please see pages 3 to 5 of this Plan Booklet or contact the Claim Administrator for a list of services for which pre-service approval (prior authorization or certification) is required. If you fail to obtain prior approval for these services, your benefits may be denied or reduced.

Urgent care claims: Your request for a required prior authorization will be considered an *urgent care claim* if it needs expedited handling. In other words, your pre-service claim will be considered "urgent" if applying the time frames allowed for a *pre-service claim* (generally 15 - 30 days for a request submitted with sufficient information):

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is' the subject of the claim.

The applicable urgent care claim reviewer, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above will be treated as an urgent care claim.

Concurrent care (ongoing treatment) claim: A concurrent care claim is a decision to reconsider a benefit after an initial approval was made resulting in a reduction, termination, or extension of a benefit. (For example, an inpatient hospital stay originally approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved as an urgent care claim.

Post-service claims: Any other type of health care claim is considered a post-service claim, such as a claim submitted for payment after health care services and treatment have been obtained.

Disability claims: A disability claim is a claim that requires a finding of total disability as a condition of eligibility. Under the terms of this Plan, a *disability claim* is any claim for an extension of eligibility due to disability arising prior to the date that coverage would otherwise terminate. (See page 71 of this Plan Booklet or contact the District's Benefits Department for further information about extensions of eligibility based on disability.)

Rescission of Coverage. A rescission of coverage occurs when a Participant or Dependent's coverage under the Plan is cancelled *retroactively* because a Participant has committed fraud or has intentionally

misrepresented a material fact (contact the District's Benefits Department regarding the definition of "Rescission"). When coverage is cancelled retroactively, it means that coverage will be cancelled back to the first day of enrollment in the Plan.

Situations That do NOT Constitute a "Claim for Benefits"

The following are not considered claims and are therefore not subject to the requirements and time frames described in this section:

- Simple inquiries about this Plan's provisions that are unrelated to any specific benefit claim.
- A request for an advance determination regarding this Plan's coverage of a treatment or service that does not require prior authorization.
- A prescription you present to a pharmacy to be filled. (However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section.)
- Simple requests for a determination regarding whether an individual is eligible for coverage under the Plan.
- Simple requests for a diagnosis code (and its corresponding meaning) or a treatment code (and its corresponding meaning).

Change in Claim Type
Generally, the claim type is determined at the time the initial claim is filed. However, if the nature of your claim changes as it proceeds through the claims procedures, the claim may be re-characterized. For example, a claim that was initially characterized as an *urgent care claim* may be re-characterized as a *pre-service claim* if the urgency subsides.

NOTIFICATION THAT YOUR PRE-SERVICE OR URGENT CARE CLAIM HAS NOT BEEN PROPERLY FILED
If your *pre-service claim* has not been properly filed, the applicable Claim Administrator will notify you as soon as possible but no later than 5 days after receipt of the claim of the proper procedures to be followed in filing a claim.

If your *urgent care claim* has not been properly filed, the applicable Claim Administrator will notify you as soon as possible but no later than 24 hours after receipt of the claim of the proper procedures to be followed in filing a claim.

Unless the claim is re-filed properly, it will not constitute a claim. You or your Provider will receive notice that you have improperly filed your claim only if the claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested.

TIMING OF INITIAL CLAIMS DECISION
A determination on your initial claim will be made within the following time frames:

Pre-service claims. If your pre-service claim has been properly filed, the applicable Claim Administrator will notify you of its decision within 15 days from the date your claim is received, unless additional time is needed. The time for response may be extended by up to 15 days if necessary due to matters beyond the control of the Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which a decision is expected to be made.

If an extension is needed because the Claim Administrator needs additional information from you, the Claim Administrator will notify you as soon as possible, but no later than 15 days after receipt of the claim, of the specific information necessary to complete the claim. In that case you and/or your provider will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Claim Administrator then has 15 days to make a decision and notify you of the determination.

Urgent care claim. You will be notified of a determination by telephone as soon as possible, taking into account the exigencies of your situation, but no later than 72 hours after receipt of the claim by the Claim Administrator. The plan will defer to the attending provider with respect to the decision as to whether a claim constitutes "urgent care." The determination will also be confirmed in writing. If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claim Administrator will notify you as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your provider must respond to this request within 48 hours. Notice of a decision will be provided no later than 48 hours after the Claim Administrator receives your response, but only if it is received within the required time frame.

Concurrent care decision. A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by the Claim Administrator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated. A request by you to extend approved urgent care treatment will be acted upon by the Claim Administrator within 72 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. The Plan is required to provide continued coverage pending the outcome of your internal concurrent claim appeal.

Post-service claims. Ordinarily, you will be notified of the decision on your post-service health care claim within 30 days of the date the Claim Administrator receives the claim. This period may be extended one time by up to 15 days if the extension is necessary due to matters beyond the control of the Claim Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claim Administrator expects to make a decision. If an extension is needed because the Benefits Administrator or Claim Administrator needs additional information from you, the Claim Administrator will notify you as soon as possible, but no later than 30 days after receipt of the claim, of the specific information necessary to complete the claim. You and/or your provider will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Claim Administrator then has 15 days to make a decision on your post-service claim and notify you of the determination.

Extension of Coverage for Disability claims. The District's Benefit Department will ordinarily make a decision on the claim and notify you of the decision within 45 days of receipt of the claim. This period may be extended by up to 30 days if the extension is necessary due to matters beyond the control of the District's Benefit Department. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the District's Benefit Department expects to make a decision. A decision will then be made within 30 days of the date the District's Benefit Department notifies you of the delay. The period for making a decision may be extended an additional 30 days, provided the District's Benefit Department notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the District's Benefit Department expects to render a decision. If an extension is needed because the District's Benefit Department needs additional information from you, the District's Benefit Department will notify you as soon as possible, but no later than 45 days after receipt of the claim, of the specific information necessary to complete the claim. You will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is

earlier). District's Benefit Department then has 30 days to make a decision on your claim and notify you of the determination.

Rescissions of Coverage. The District's Benefit Department will provide you with a decision on your initial appeal of a rescission of coverage. For the purposes your initial claim, *rescissions of coverage* will be subject to the same time frames which apply to *post-service claims*.

The Claim Administrator or District's Benefit Department will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim while it is under review. You will be provided with the new or additional rationale sufficiently in advance of the date on which the Claim Administrator, or the District's Benefit Department is required to provide you with an adverse benefit determination. This is to give you time to respond to the new or additional rationale.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

You will be provided with written notice of a determination denying your claim, whether your claim is denied in whole or in part. This notice will include the following:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). You have the right to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. These will be provided to you free of charge upon your request.
- The specific reason(s) for the denial.
- The denial code and its corresponding meaning.
- A reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information needed to process your claim, as well as an explanation of why the additional material or information is needed.
- A description of the Plan's review procedures and the time limits that are applicable to them if you appeal and the claim denial is upheld at the initial level, as well as a description of the external review process and information regarding when and how to initiate an external appeal.
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision.
- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- In the case of a final adverse benefit determination following your appeal of the initial adverse benefit determination, a discussion of the reasons for the decision.
- The contact information for the District's Benefit Department and the Department of Health and Human Services Insurance Assistance Team (1-888-393-2789).

For *urgent/concurrent* claims:

- The Claim Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claim Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.
- For *pre-service* and *urgent care claims*, you will receive notice of the determination even when the claim is approved.

HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION
You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The time frame allowed for the Claim Administrator, or the JHMB Board of Directors to complete its review of your appeal is dependent upon the type of review involved (*e.g*. pre-service, concurrent, post-service, urgent, disability, or rescission).

Pre-Service Claims, Urgent Care Claims, Concurrent Care Claims, Post-Service Claims
The Plan offers one level of appeal which will be heard by the applicable Claim Administrator. You will not be charged any fees to file an appeal.

For *pre-service claims* involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claim Administrator's decision, can be sent between the Benefit Administrator or Claim Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claim Administrator by phone and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by you or your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (*e.g*. urgent care).

Appeals of Disability Extension of Coverage
If your disability claim is denied by the District's Benefit Department, the JHMB Board of Directors will offer a single mandatory level of appeal.

You or your authorized representative must submit a written request for an appeal to the JHMB Board of Directors at the following address:

Attn: JHMB Board Administrator
Post Office Box 2330
Stockton, CA 95201

Appeals of Rescission of Coverage
If your initial appeal of a rescission of coverage is denied by the District's Benefit Department, the JHMB Board of Directors will offer a single mandatory level of appeal.

You or your authorized representative must submit a written request for an appeal to the JHMB Board of Directors at the following address:

Attn: JHMB Board Administrator
Post Office Box 2330
Stockton, CA 95201

HOW YOUR APPEAL WILL BE DECIDED
When the Claim Administrator, or the JHMB Board of Directors, (the "Reviewer") considers your appeal, it will not rely upon the initial benefit determination. The review will be conducted by persons who did not make the initial determination and who do not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the Reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. Upon your request, the Reviewer will identify the health care professional whose advice was obtained in connection with the initial determination, whether or not it was relied on.

Upon request, the Reviewer will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- Is a statement of the plan's policy or guidance concerning the treatment or benefit relative to your diagnosis.

The Reviewer will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. You will be provided with the new or additional rationale sufficiently in advance of the date on which the Reviewer is required to provide you with the final adverse benefit determination. This is to give you time to respond to the new or additional rationale.

You do not have the right to personally appear before the Reviewer unless the Reviewer, in its sole discretion, concludes that such an appearance would be of value in enabling it to review the initial adverse determination.

NOTIFICATION OF THE OUTCOME OF THE APPEAL
If you appeal a *pre-service claim*, the Reviewer will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a claim involving *urgent/concurrent care*, the Reviewer will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal a *post-service claim*, the Reviewer will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

If you appeal the initial decision of your extension of coverage due to a *disability claim*, the JHMB Board of Directors will notify you of the outcome of the appeal within 45 days after receipt of your request for appeal. This period can be extended for an additional 45 days if it determined that special circumstances exist. If an extension is needed you will be notified in writing of the need for an extension prior to the expiration of the first 45 day period, of the circumstances requiring the extension, and the date by which the District's Benefit Department expects to reach a decision.

If you are appealing the District's Benefit Department initial decision of your *rescission of coverage*, the JHMB Board of Directors will notify you of the outcome of the appeal within 60 days after the receipt of your request for appeal.

DENIAL OF YOUR APPEAL
If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Reviewer will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

You may have reasonable access to all records relevant to your claim and may receive copies at no charge upon written request. If an internal rule, guideline, protocol, or other similar criterion was used in the appeal denial, you will be told about it and may receive a copy of it. If the denial is based on medical necessity or the treatment's being experimental or investigational or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

If you waive your right to appeal or receive a final adverse benefit determination, such waiver or the final adverse benefit determination is final and binding upon all parties, subject only to the External Review Procedures described immediately below or any civil action you may bring following such external review. Following issuance of the written final adverse benefit determination there is no further right of internal appeal. Please note that if your claim is eligible for external review you are required to exhaust the External Review Procedures immediately below before you may file a legal claim in state or federal court.

EXTERNAL REVIEW PROCEDURES

Until further guidance is issued, you may only request an external review of claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or (2) a rescission of coverage.

If your claim involved a medical judgment or a rescission of coverage, and the outcome of the final internal appeal is adverse to you, you may be eligible for an external review pursuant to federal law. This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above; it is voluntary. Your decision to seek external review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state or federal laws. If your claim is denied following an independent external review, no lawsuit or legal action of any kind may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the external review decision on the claim.

REQUEST FOR EXTERNAL REVIEW
You or your authorized representative must submit your request for external review within four (4) months of the notice of your final internal adverse benefit determination. A request for an external review must be in writing and must be sent to the Department of Health and Human Services ("HHS"):

Via Email:	**Via Fax:**	**Via Mail:**
disputedclaim@opm.gov	(202) 606-0036	P.O. Box 791 Washington, DC 20044

The HHS examiner who reviews your External Review request will be an independent third party with clinical and legal expertise and with no financial or personal conflicts with the Plan. If you have any questions or concerns during the external review process you can call HHS at the following toll-free number: (877) 549-8152.

You do not have to resend the information that you submitted for your internal appeal. However, you are encouraged to submit any additional information that you think is important for review to the mailing address above. Any additional information you submit to the HHS will be shared with the Plan in order to give the Plan an opportunity to reconsider the denial.

When the HHS examiner receives your request for external review the review will contact the Plan. Within five (5) business days of the HHS examiner's request, the Plan must provide the following documents to HHS:

- The Certificate of Coverage;

- A copy of the adverse benefit determination;
- A copy of the final internal adverse benefit determination;
- A summary of the claim;
- An explanation of the Plan's adverse benefit determination and final internal adverse benefit determination; and
- All documents and information considered in making the adverse benefit determination or final internal adverse benefit determination including any additional information that may have been provided to the Plan or relied upon by the Plan during the internal appeals process.

The HHS examiner will make a preliminary review of your request for external review following the receipt of your request. This review will determine whether:

- You have exhausted the Plan's internal claims procedures;
- The denial of benefits relates to your failure (or the failure of your Dependent) to meet the Plan's eligibility requirements;
- You are or were covered under the Plan at the time the initial claim for health care was requested; and
- You have provided all information and forms needed to process the external review.

If your request is complete, but not eligible for external review, the HHS examiner will notify you and the Plan in writing. If your request is not complete, the notice will describe the information you or the Plan need to provide to make your request complete.

THE REVIEW PROCESS

The HHS examiner will review all the information and documents timely received. In reaching a decision, the HHS examiner will review the claim "de novo" ("afresh") and will not be bound by any decisions or conclusions reached during the internal claims and appeals process.

Reconsideration by the Plan

The HHS examiner will forward any documents submitted directly to the HHS examiner by the claimant to the Plan within one (1) business day of their receipt. Upon the receipt of such information the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination, however this reconsideration will not delay the external review. The external review will only be terminated as a result of the Plan's reconsideration if the Plan decides to reverse its adverse benefit determination or final adverse benefit determination. Within one (1) business day of making its decision to reverse, the Plan must provide written notification of its decision to you and the HHS examiner. The HHS examiner will terminate the external review upon receipt of this notice.

The Decision of the HHS Examiner

The HHS examiner must provide written notice to you and the Plan of the final external review decision within 45 days after the HHS examiner receives the request for the external review.

The HHS examiner's final external review decision will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and the corresponding meaning). If the notice involves a denial unrelated to a specific claim, only the name and the ID number will be provided;
- The date the HHS examiner received assignment to conduct the external review and the date of the HHS examiner's decision;
- References to the evidence or the documentation, including the specific coverage provisions and evidenced-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for the decision, including the rationale and any evidence-based standards that were relied on;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- The current contact information for any applicable ombudsman.

After the final external review decision, the HHS examiner will maintain records of all claims and notices associated with the external review process for six (6) years. The HHS examiner must make such records available for examination by you and the Plan upon request.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

REQUEST FOR AN EXPEDITED EXTERNAL REVIEW
You may make a written or oral request to HHS for an expedited external review if you receive:

- An adverse benefit determination or final adverse benefit determination which involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal (*i.e.*, and *urgent* claim); or
- An adverse benefit determination or final adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which you receive services, but have not been discharged from a facility, and you have filed a request for an expedited internal appeal (*i.e.*, a *concurrent* claim).

A request for an expedited external review can be made by calling HHS at the following toll-free number: (877) 549-8152.

The HHS examiner will contact the Plan immediately upon your request for an expedited external review. Immediately upon request of the HHS Examiner, the Plan must provide the information detailed above under "Request for External Review." If the HHS examiner determines that you are not eligible for an expedited external review, the HHS examiner will notify you and the Plan as soon as possible.

The Review Process

The review process detailed above will be followed by the HHS examiner. However, the HHS examiner will provide you and the Plan with notice of the final external review decision within 72 hours of receipt of the request for an expedited external review. This notice can be provided orally, but will be followed by written notice within 48 hours.

In the event that the Plan makes the decision to reverse its adverse benefit denial upon reconsideration, the notice of the Plan's decision can be provided to you and the HHS examiner orally, but must be followed by written notice with 48 hours.

OTHER IMPORTANT INFORMATION

REQUIREMENT TO FILE A REQUEST FOR EXTERNAL REVIEW BEFORE FILING A LAWSUIT
No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of a final external review decision on the claim or other request for benefits. You must exhaust the Plan's internal and external claims and appeals procedure before filing a lawsuit or taking other legal action of any kind against the Plan.

If the Plan fails to adhere to the internal claims process described above, the Plan's claims and appeals procedure will be deemed exhausted and you can seek immediate review by a court or request external review, unless the failure was: de minimis; non-prejudicial; attributable to good cause or matters beyond the Plan's control; in the context of an ongoing good-faith exchange of information; and not reflective of a pattern or practice of non-compliance. You are entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets the foregoing standard so that you can make an informed decision about whether to seek immediate review. If the external reviewer or the court rejects your request for immediate review on the basis that the Plan meets the foregoing standard you have the right to resubmit and pursue the internal appeal of the claim.

If the Plan decides an internal appeal is untimely (*e.g.*, you do not appeal with 180 calendar days of being notified of the adverse benefit determination), the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

LEGAL STANDARD OF REVIEW
The Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department and any applicable Claim Administrator retain full discretionary authority to (a) determine all facts relevant to any claim (b) to construe the terms of the Plan and all other documents relevant to the Plan, and (c) to determine which benefits are payable from the Plan.

Any decision made by the Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department or any applicable Claim Administrator shall be binding on all persons affected to the fullest extent permitted by law.

No decision made by the Benefits Administrator, the JHMB Board of Directors, the District's Benefit Department or any applicable Claim Administrator shall be revised, changed or modified by court unless the party seeking such action is able to show by clear and convincing evidence that that decision made by the Benefits Administrator, JHMB Board of Directors, the District's Benefit Department or applicable Claim Administrator on appeal was an abuse of discretion in light of the information actually available to it at the time of its decision.

PLAN RECORDS
The Plan's Benefits Administrator will maintain records designed to ensure and verify that determinations are made in accordance with the Plan documents and applicable law, and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated claimants. Your privacy will be protected in accordance with applicable state and federal law.

The JHMB Board of Directors reserves the right to modify the policies, procedures and timeframes in this section. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the JHMB Board of Directors reserves the right to adopt such rules as it in its discretion deems necessary and appropriate to provide claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.