Article V — Claims Procedure

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Article V — Claims Procedure

§ 20A-501 Filing a Claim.

A Participant or his/her authorized representative shall make a claim for benefits under this Plan by filing a written request with the Administrator in accordance with the provisions of § 20A-402. The claims procedure set forth in the remainder of this Article shall be interpreted in accordance with the provisions of 45 CFR § 147.136 (including the incorporated provisions of 29 CFR § 2560.503-1). It is not expected that this Plan will involve any claims involving urgent care, any pre-service claims, or any concurrent care claims, as described in those regulations, and so provisions applicable to such claims are not included explicitly in this Article. However, this Plan incorporates by reference the provisions of those regulations applicable to such claims in the event any of them should arise.

§ 20A-502 Notice of Denial.

If the Administrator denies a request for benefits under § 20A-402 or § 20A-501 in whole or in part, it shall notify the claimant of the same in writing within 30 days of the date the request was filed with the Administrator (or earlier, if required by applicable law). (However, this 30-day period may be extended one time by the Administrator for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Administrator expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically

describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In that event, the time period for processing the claim shall not begin to run again until the information is received from the claimant or his/her authorized representative.) Any notice of denial shall contain, in a manner calculated to be understood by the claimant—

(a) the reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

(b) specific references to the Plan provisions on which the denial is based;

(c) a description of any additional information needed to perfect the claim and an explanation of why such information is necessary;

(d) an explanation of the Plan's claim procedure, including the opportunity for appeal and review, applicable time limits, and how to initiate an appeal and review under the following provisions of this Article;

(e) in the event an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination, a copy of such rule or guideline, etc. shall be attached;

(f) if the determination was based on a medical necessity, experimental, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claimant's medical circumstances shall be attached;

(g) a statement indicating that the claimant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(h) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(i) a statement that, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided; *and*

(j) contact information for the office of health insurance consumer assistance or ombudsman.

If such notification is not given within the above 30 day (or shorter) period, the claimant may consider the claim denied as of the last day of such period.

§ 20A-503 Internal Appeal of Denial.

(a) Petition. A claimant or his/her authorized representative may petition the Administrator in writing for an internal appeal of the denial of any claim within 180 days after the receipt of a notice of denial under § 20A-502, or at any time after the claimant may consider his claim denied under § 20A-502 and before the claimant receives a formal notice from the Administrator under § 20A-502. A claimant should submit written comments, documents, records, and all other information relating to the claim for benefits. A claimant may request reasonable access to and

copies of all documents, records, and other information relevant to the claim, which shall be provided to the claimant free of charge. The appeal before the Administrator will take into account all comments, documents, records and other information that is submitted, regardless of whether such information was submitted and considered in the initial determination of the claim. The claimant will also be provided an internal appeal that does not afford deference to the initial adverse determination, and which is conducted by someone who is neither the individual who made the initial determination, nor the subordinate of such individual. If any new or additional information is considered, relied upon, or generated by or at the direction of the Plan or the Administrator in connection with the internal appeal, such evidence must be provided, free of charge, to the claimant as soon as possible and sufficiently in advance of the date by which the notice of final internal appeal determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(b) Medical Judgment. If the internal appeal before the Administrator involves a determination based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational, or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the review will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the appeal.

(c) Final Decision by Administrator. If the Administrator still denies the claim following an appeal under subsection (a), the Administrator shall so notify the claimant in writing in accordance with the same procedures set forth in § 20A-502 for the initial determination of the Administrator (except that the 30 day period for making a decision shall not be extended). In addition, the denial shall include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(d) New or Additional Rationale. Notwithstanding subsection (c), if a claim denial under subsection (c) is based on a new or additional rationale from that stated in the initial determination under § 20A-502, the claimant must be provided, free of charge, with the rationale; and the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal appeal determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(e) Avoiding Conflicts of Interest. In addition to the other requirements of this Section, the Plan and the Administrator must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjuster or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

§ 20A-504 External Review.

(a) State Procedure. If this Plan is subject to a Pennsylvania external review procedure that applies to and is binding on this Plan, which includes at a minimum the consumer protections in the NAIC Uniform Model Act (within the meaning of 45 CFR § 147.136), then this Plan must comply with the applicable Pennsylvania external review process and is not required to comply with the Federal external review process under subsection (b).

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d) (except with respect to a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a person fails to meet the requirements for eligibility under the terms of the Plan). Until further information is provided by the regulatory agencies, a Federal external review must be filed by the claimant or his/her authorized representative with the external reviewer within four (4) months of the date the claimant was served with the decision under § 20A-503, or the claimant shall lose the right to an external review and appeal. The Plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the Plan, the claimant provided all of the necessary information to process the external review, and that the claimant has exhausted the internal appeals process. The Plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan will permit the claimant to perfect the external review request within the four (4) month period or, if later, 48 hours after receipt of the notice. The Plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify the claimant and the Plan Administrator of its decision within 45 days after its receipt of the request for external review. The external reviewer's decision is binding on the parties unless other State or Federal law remedies are available. The Plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011. The Administrator, on behalf of the Plan, shall contract with at least three IROs and must rotate assignments among the IROs.

§ 20A-505 Adverse Benefit Determination.

The provisions of this Article V with respect to the denial, appeal, and review of a claim shall also apply to all other adverse benefit determinations as defined in 29 CFR § 2560.503-1, as

well as any rescission of coverage, as described in 45 CFR § 147.128, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.