Priority Health

Appeal Process for Fully Funded Employer Group Member

Inquiry, appeal and expedited review procedure notification

Your confidence in us and your satisfaction with our services is very important. We understand that there will be times when you will have a concern or a problem you want us to address. As a first step, we ask that you contact our Customer Service department. Our representatives are available to help you with your concerns as quickly as possible.

Here's how to reach Customer Service:

Online: Visit *priorityhealth.com/contact-us*

Phone: Call the Customer Service number on the back of your ID card.

Hours: Customer Service hours vary depending on your Priority Health plan. Please visit *priorityhealth.com/contact-us* for your plan specific hours.

If you need help understanding this information, contact Customer Service for free language translator services.

If you are not satisfied with the answers provided to you by Customer Service, you can then formally request that Priority Health change the response or decision provided. You or someone acting on your behalf, including an attorney, can send us a formal complaint called an appeal. You must file an appeal within 180 days from the date you learn of the decision you do not agree with. You can file an appeal to ask us to change a decision about any of the following:

- Benefits (may include experimental or investigational or not medically necessary or appropriate)
- Eligibility or cancellation of your coverage
- Payment of claims (in whole or in part)
- How we've handled payment or coordination of health care services
- Contracts with our providers
- Availability of care or providers
- A decision not in your favor. This may include services that have been reviewed by Priority Health and denied, reduced or terminated. It also may include a slow response to a request for a decision from us.

continued >

Appeal process overview

Here is a summary of the appeal process

1 | **Filing a Level 1 Appeal with Priority Health**

If you are not satisfied with the outcome of Step 1, you can choose to proceed to Step 2.

2 | **Filing a Level 2 Appeal with Priority Health**

If you are not satisfied with the outcome of Step 2, you can choose to proceed to Step 3.

3 | **Requesting an External Appeal with the State of Michigan.**

If your request involves a medical emergency, refer to the Expedited Review section.

Send us your appeal in one of these ways:

- Submit the appeal form online at *priorityhealth.com*
- Email, fax or mail a paper form. You can download the appeal form from *priorityhealth.com* or call Customer Service at the number on the back of your member ID card to request a form be mailed to you. You must provide this same information if you are requesting an Expedited Review (see page 3 for criteria for an Expedited Review).
- Your name
- Your signature
- Your address
- Your member and/or beneficiary number
- Your reason for asking for the Internal Appeal
- Anything you want us to look at, such as medical records, doctor's letters or other information that tells us why you need the item or service, and
- If you want a standard or fast appeal (for a fast appeal, tell us why you need one). If you are asking for a fast appeal you will need a doctor's letter that supports why you need this. Call your doctor if you need this information.

  Please keep a copy of everything you send us for your records.
  - Email form with documentation to: *phmemberappeals@priorityhealth.com*
  - Fax it to: 616.975.8894
  - Mail it to: Priority Health
    Appeal Analyst, MS 1145
    1231 E Beltline NE
    Grand Rapids, MI 49525
- Call the number on the back of your member ID card and one of our Customer Service representatives will complete an appeal form on your behalf.

Step 1: Filing a Level 1 Appeal with Priority Health

How do I file a Level 1 Appeal with Priority Health?

Contact our Customer Service department to file an
appeal with us. Our representatives will ask you to fill out
an appeal form to tell us about your complaint. They can help you fill out this form. You can also include extra information if you wish.

Who reviews an appeal?

The person or persons who review your appeal are not the same individuals who were involved in the initial decision (or determination) provided to you. Review by the Appeal Committee always includes the opinion from a doctor for health issues.

What happens after this review?

After we receive your request and have collected all relevant information from health care providers or facilities, our Appeal Committee will meet to review your case. Once a decision has been made, we will mail you a written response. However, if you are not satisfied with the outcome, you can ask for another review called a
Level 2 appeal. (see Step 2, Filing an Level 2 appeal).

How long will it take for me to get an answer?

If services have not been received
(this means that you have not yet received the medical services you're filing an appeal for):

Steps 1 (filing a Level 1 appeal) and 2 (filing a Level 2 appeal) combined must be completed with a final decision made within 30 calendar days after we receive your appeal forms. The 30 calendar days do not include any days you or your representative may delay the process.

If services have been received
(this means that you have already received the medical services you are filing an appeal for):
Steps 1 (filing a Level 1 appeal) and 2 (filing a Level 2 appeal) combined must be completed with a final decision made within 60 calendar days after we receive your appeal forms. The 60 calendar days do not include any days you or your representative may delay the process

If we receive your appeal form during non-business hours, we count the time of receipt as the next business day.

Step 2: Filing a Level 2 Appeal with Priority Health

If you disagree with the decision provided by the Level 1 Appeal Committee, you can ask for another review by completing a Level 2 appeal form. You have 90 days from the date you learn of the Level 1 appeal decision to file a Level 2 appeal with us. You can include extra information if you wish.

Who reviews appeals?
The person or persons who review your Level 2 appeal are not the same individuals who were involved in the Level 1 appeal decision. Review by the Level 2 Appeal Committee always includes an opinion from a doctor for health issues.

What happens during this review?
After we receive your Level 2 appeal, the Level 2 Appeal Committee will then review your case. You will be provided with the date, time and place of your review after we have received your request for an appeal. You will also be given a full description of what will happen during the review, as well as, a copy of the materials that will be reviewed by the Level 2 Appeal Committee free of charge. You and/or a representative can also choose to participate during the review, where you will have the chance to speak to the Level 2 Appeal Committee members.

What happens after this review?
The Level 2 Appeal Committee will make a decision and we will mail you a written response within five business days of the review. If you have gone through Steps 1 and 2 (above) and are dissatisfied with the decision, you may ask for a review by the State of Michigan or take civil action.

How long will it take for me to get an answer?

If services have not been received
(this means that you have not yet received the medical services you're filing an appeal for):
Steps 1 and 2 combined must be completed with a final decision made within 30 calendar days after we receive your appeal forms. The 30 calendar days do not include any days you or your representative may delay the process.

If services have been received
(this means that you have already received the medical services you are filing an appeal for):
Steps 1 and 2 combined must be completed with a final decision made within 60 calendar days after we receive your appeal forms. The 60 calendar days do not include any days you or your representative may delay the process. If we receive your appeal form during non-business hours, we count the time of receipt as the next business day.

What can I do if I'm still not satisfied with the decision?

- You may bring a civil action under Sec. 502(a) of ERISA within three years after the date of service or after you learned coverage was denied; and/or
- You may ask for an external review through the Department of Insurance and Financial Services (DIFS).

Priority Health Expedited Review (Emergency Review)

Priority Health will follow a faster review process when there is a medical emergency.

How long does this process take?
We will make a decision within 72 hours (3 days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 877.954.1035 (toll free) to make a request.

When can I ask for an expedited review?
The faster process will be followed when you file a complaint (verbally or in writing) and when the normal time to review your case (Steps 1 and 2 of the appeal process) would:

- Put your life in danger
- Interfere with your full recovery, or
- Delay treatment for severe pain (must be confirmed by your doctor)

What happens after this review?
We will tell you by telephone right after we make the decision. We will also send a letter telling you about the decision within three calendar days after the decision. If you are not satisfied with the final decision, you may appeal to the State within 10 days after you receive the final decision about your expedited review.

The State will follow a faster review process when there is an emergency.

When can I ask for the State's expedited review?
An expedited review by the State may be asked for if:

- Your doctor tells the State by phone or in writing that the Priority Health review time would put your life in danger, or would interfere with your full recovery, and
- You have already asked for an expedited review by Priority Health.
- Note: Your expedited, external review by the State can happen at the same time you are using the internal Priority Health appeal process for urgent care and ongoing treatment.

Step 3: Requesting an External Review (State of Michigan)

If you disagree with the decision provided by the Level 1 and Level 2 Appeal Committees, you may request an external review with the Department of Insurance and Financial Services (DIFS).

How do I request an external review?
To request an external review, you need to fill out and send to DIFS the *Health Care-Request for External Review Form* which will be provided to you by Priority Health upon completion of the appeal process. This form can also be found on the DIFS website listed below. This must be sent to DIFS no later than 127 days after you receive notice of a decision not in your favor. If Priority Health does not meet the timeline requirement for both Step 1 and 2 combined of the internal appeal process, you may also request an external review by DIFS. If you have given Priority Health more time for a decision, you may not request an external review until Priority Health has made its decision.

What information does DIFS need?
A *Health Care-Request for External Review Form* must be sent to DIFS. This allows Priority Health and providers to disclose your personal health information to DIFS. You may also give other information about your case to DIFS.

How to contact DIFS:
Department of Insurance and Financial Services –
Office of General Counsel – Appeals Section
P.O. Box 30220
530 W. Allegan Street, 7th floor
Lansing, MI 48909-7720
Fax: 517.284.8838
Phone: 877.999.6442
www.michigan.gov/difs

What does DIFS do when I send them a request for external review?

DIFS will inform Priority Health that they received your request. Within five days, DIFS will review your request to decide these things:

- If you or your dependent are or were covered under Priority Health.
- If the services seem to be a covered benefit.
- If you have completed both levels of the Priority Health appeal process (unless it is not required).
- If you have provided all the information you would like to be reviewed.
- If you have sent in the necessary form.

When this review is complete, DIFS will inform you if your request is complete and if it has been accepted.

- If your review is accepted, DIFS will inform you in writing and allow you to send any additional information you would like reviewed.
- If your review is not accepted, DIFS will inform you in writing and explain the reason that it was not accepted.

What happens during the standard external review process?

- DIFS informs Priority Health of the external review and requests information about your case.
- DIFS will inform you if your case is accepted for external review and if an Independent Review Organization (IRO) will be reviewing your request.
- You have 7 business days to send any additional information to the IRO.
- Priority Health will send to the IRO any documents or information that was used to make the decision.
- The IRO will review your request and make a recommendation within 14 days from receiving your request.
- Please note that only requests that involve medical issues are reviewed by an IRO. Complaints about non-medical or contractual issues may be reviewed by DIFS.

What happens during the expedited external review process?

- DIFS informs Priority Health of the expedited external review and requests information about your case.
- If DIFS accepts your case for expedited external review, your case will be reviewed by an IRO.
- Priority Health will send to the IRO any documents or information that was used to make the decision within 12 hours from receiving the notice.
- The IRO will review your request and make a recommendation within 36 hours after receiving your request.
- DIFS will review the IRO recommendation and issue a decision within 24 hours.

What information will DIFS or the IRO review?

- Medical records related to the case
- The doctor or health care professional recommendations
- Opinions from similar health care professionals and other documents sent in
- Terms of benefit plan coverage
- Most appropriate practice guidelines
- Clinical review criteria developed by Priority Health that relates to your case

What happens after the external review is complete?

- If an IRO is involved in your case, the IRO will send a recommendation to DIFS.
- DIFS will review the IRO recommendation to make sure it agrees with the terms of your policy.
- DIFS will review your request and will notify you and Priority Health of its decision.
- If DIFS reverses the Priority Health decision, Priority Health will comply with the decision within 7 business days or seek judicial review.

Priority Health

Notice of Nondiscrimination and Language Assistance Services

Priority Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Federal law requires that we provide you with this Notice of Nondiscrimination and Language assistance services.

Free aids and services

Priority Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Priority Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Priority Health customer service by calling the number at the back of your membership ID card (TTY users call 711).

To file a civil rights grievance

If you believe that Priority Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Priority Health Compliance Department
Attention: Civil Rights Coordinator
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501
Toll free: 866.807.1931 (TTY users call 711) Fax: 616.975.8850
PH-compliance@priorityhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Priority Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov* or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at *hhs.gov/ocr/office/file/index.html.*

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم:711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請撥打會員卡背面的客服電話 (TTY: 711）。

ܙܘܗܪܐ: ܐܢ ܐܲܚܬܘܿܢ ܟܐ ܡܗܲܡܙܸܡܝܼܬܘܿܢ ܠܸܫܵܢܵܐ ܣܘܼܪܝܝܐ (ܐܵܬܘܿܪܵܝܵܐ) ، ܬܚܝ ܒܬܘܢ ܦܠܚܬܘܢ ܝܠܗܝܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܵܢܵܐܝܼܬ. ܐܢ ܡܨܫܟܠܚܝܬܘܢ ܩܪܘܢ ܠܡܢܝܢ ܕ ܡܢܝܢܐ ܕܬܫܡܫܬܐ ܕܝܗܒܬܐ ܥܠ ܡܢܝܢܐ ܕܐܝܬܗ ܠܒܣܬܪܐ ܕܦܬܩܐ ܕܗܘܝܬܐ ܕܗܕܡܘܬܐ. (TTY: 711)

CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin hãy gọi tới số điện thoại của bộ phận dịch vụ khách hàng có ở mặt sau thẻ ID thành viên của quý vị. (TTY: 711).

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Ju lutem kontaktoni qendrën e shërbimit për klient në pjesën e pasme të ID kartës tuaj të anëtaresimit (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 멤버쉽 ID카드의 뒷면에 있는 고객 서비스 번호로 전화해 주십시오. (TTY: 711)

লক্ষ্য করুনঃ আপনি বাংলায় কথা বলতে পারলে আপনার জন্য নিঃখরচায় ভাষা সহায়তা সেবা সুলভ রয়েছে। অনুগ্রহ করে আপনার সদস্যপদ আইডি কার্ডের পেছনে থাকা গ্রাহক সেবা নম্বরে কল করুন। (TTY: 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer telefonicznej obsługi klienta wskazany na odwrocie Twojej legitymacji członkowskiej (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienste zur Verfügung. Bitte rufen Sie die Kundendienstnummer auf der Rückseite Ihrer Mitgliedskarte an. (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero sul retro della tessera identificativa di membro. (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。メンバーシップIDカードの裏面にあるお客様サービスセンターの番号までお電話にてご連絡ください。(TTY: 711).

ВНИМАНИЕ! Если Вы говорите на русском языке, то Вам доступны услуги бесплатной языковой поддержки. Пожалуйста, позвоните в службу поддержки клиентов по номеру, указанному на обратной стороне Вашей идентификационной карточки участника (телетайп (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Molimo nazovite broj službe za korisnike na pozadini vaše članske iskaznice (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog,mga serbisyo ng tulong sa wika, ng libre, ay available para sa iyo. Pakitawan ang numero ng customer service sa likod ng iyong ID card ng pagiging miyembro. (TTY: 711).