Priority Health Insurance Company Appeal Process

Inquiry, appeal and expedited review procedure notification

We hope that you are always happy with the services you receive from Priority Health. If you have any questions or concerns, please call our Customer Service department. Our representatives will help you with your problem as quickly as possible.

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

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 are not happy with the answers that our representative has provided, you or someone acting on your behalf, including an attorney, can send us a formal complaint. This formal complaint is called a grievance. You have two years from the date you learn of a problem to file a grievance with us. You can file a grievance to ask us to change a decision about any of the following:

- Benefits (including services determined to be experimental or investigational or not medically necessary or appropriate)
- Eligibility
- 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
- Delivery or quality of health care services or
- 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.
- Rescission of coverage

Appeal process overview

Here is a summary of the grievance process

1| Filing a Level 1 Appeal with Priority Health.
If you are not satisfied with the outcome of Step 1, you can 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 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.
  - Email from 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 a Level 1 Appeal with us. Our representatives will ask you to fill out a Level 1 Appeal help you fill out this form. You can include extra information if you wish. Note: You are not required to use the Level 1 Appeal Form to file a request for appeal.
You must provide this same information if you are requesting an Expedited Review (see page 4 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. Youmay file a request by letter, fax, email or phone.

Who reviews a Level 1 Appeal?
The person or persons who review your Level 1 Appeal are not the same individuals whowere 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.

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

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 a 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 received the medical servicesyou're filing a grievance for): Steps 1 (filing a Level 1 appeal)and 2 (filing a Level 2 appeal) combined must be completedwith a final decision made within 30 calendar days after wereceive your Level 1 and Level 2 appeal forms. The 30 calendar days do not include any days you or yourrepresentative 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 an Level 2 appeal) combined must be completed with a final decision made within 60 calendar days after we receive your Level 1 and Level 2 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 an Level 2 Appeal

If you disagree with the decision provided by the Level 1 Appeal Committee, you can ask for another review by completing an Appeal Form. You have 90 days from the dateyou learn of the Level 1 decision to file a Level 2 appeal withus. 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 decision. Review by the Appeal Committee always includes an opinion from a doctor for health issues.

What happens during this review?

After we receive your appeal, the Appeal Committee will thenreview your case. You will be provided with the date, time and place of your review after we have received your requestfor 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 participate in 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 full business days of the review. If you have gone through Steps 1 and 2 (above) and are still 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: Steps 1 and 2 combined must be completed with a final determination made within 30 calendar days after we receive your grievance and appeal forms. The 30 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 15 days, respectively.
- If services have been received: Steps 1 and 2 combined must be completed with a final determination made within 35 calendar days after we receive your grievance and appeal forms. The 35 calendar days do not include any days you or your representative may delay the process. Neither the grievance step nor the appeal step may take more than 30 days, respectively. If we receive your grievance or appeal form during non-business hours, we count the time of receipt as the next business day. Our Grievance Committee meets at least once a week. Our Appeal Committee meets every 14 days. Both committees may meet more often to meet these timeframes.

What can I do if I'm still not happy 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).

Step 3: External review (State of Michigan)

If you ask for a review with DIFS, they will first determine:

- If your request is complete.
- If your request is accepted for external review.

If accepted for external review, your request will be assigned to an Independent Review Organization (IRO). You will not pay for any of the costs of the independent review.

How do I request an external review?

To request a review, you need to complete the form provided by Priority Health and contact the State. This form can also be found on the DIFS website listed below. This must be done no later than 60 days after you get a notice of a decision not in your favor from Priority Health. If Priority Health does not meet the timeline requirement for both Step 1 and 2 combined of the internal grievance process, you may also request a review by the State. If you have given Priority Health more time for a decision, you may not request a review until Priority Health has made its decision.

What information does DIFS need?

A Health Care-Request for External Review Form must be turned in to the State. This allows Priority Health and doctors to tell the State about your personal health information. You may also give other information about your case.

Here's how to contact the State:

Department of Insurance and Financial Services
Office of the General Counsel/PRIRA
Lansing, MI 48909-7720
877.999.6442
michigan.gov/difs

What does the State do when I send them a complaint?

The State tells Priority Health that they received your complaint. Within five business days, the State does a review 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 gone through the Priority Health grievance process (unless it is not required).
- If you have given all the information you would like to be reviewed.
- If you have sent in the necessary form.

When this review is done, the State will tell you if your request is complete and if it has been accepted. If accepted, the State must:

- Tell you that you may send in additional information within seven business days.
- Tell Priority Health that your review request has been accepted.

If your review is not accepted, the State must tell you why. If it is not accepted due to incomplete information, the State must send you a letter to tell you what is missing.

What happens during the review process?
If your review request is accepted, an IRO is asked to perform the review and to make a recommendation to the State within 14 calendar days.

- The State gives the information you sent in to the IRO and to Priority Health.
- You and Priority Health will both receive letters telling the name of the IRO that will do the review. You have seven business days to send additional information to the IRO.
- Within seven business days after the letter, Priority Health must give the IRO any documents or information used to make the decision not in your favor. If Priority Health does not do this in seven business days, the State can reverse Priority Health's decision.
- Please note that complaints about medical issues are reviewed by an IRO. Complaints about non-medical contractual issues may be reviewed by the Director of DIFS and/or an IRO.

What does the IRO look at during the 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 review is done?

- The IRO must send a recommendation to the of DIFS within 14 calendar days.
- The Director reviews to make sure it agrees with the terms of coverage.
- The Director tell you and Priority Health of the decision within seven business days after getting the recommendation.
- If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Priority Health expedited review (emergency review)

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

How long does this process take?
We will make a decision within 72 hours (three 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) when the normal time to review your case (Steps 1 and 2 of the grievance 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 two business days after the decision. If you are not happy 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 Priority Health's 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 appeals process for urgent care and ongoing treatment.

State of Michigan expedited review (emergency external review)

How do I ask for the State's expedited review?
Priority Health will provide you with a Health Care-Request for External Review Form to start this process. You may also contact DIFS to get this form.

How long does this process take?
The State's expedited review will be done within 72 hours (three days) from the time the State gets it from you.

What information does DIFS need?
A Health Care-Request for External Review Form must be turned in to the State. This allows Priority Health and doctors to tell the State about your personal health information. You may also give other information about your case.

What happens during the State's expedited review?
Here's what happens at the State when you send in your request:

- The State tells Priority Health and decides if the request meets the requirements for an expedited external review.
- If accepted, your case is reviewed by an IRO, and they will determine if you need to complete a Priority Health expedited internal review first. If this occurs, it will be sent back to follow the Priority Health process.
- If accepted for an expedited external review, Priority Health must provide all paperwork and information to the IRO within 12 hours after we receive notice.
- The IRO must make a recommendation within 36 hours after getting the request.
- The Director reviews the recommendation from the IRO. The Director makes a final decision within 24 hours after receiving the recommendation.

What happens after this review?
If the Priority Health decision is reversed, we must approve coverage or pay claims right away.

Who decides which IRO reviews the complaints?
The Director of DIFS must approve IROs. IROs cannot be owned or controlled by, be subsidiary of or in any way owned or controlled by or exercise control with the health plan; a national, state or local trade association of health benefit plans; or a national, state or local trade association of health care providers.