Priority Health

How to resolve a problem you're having with Priority Health Managed Benefits

Self-funded Non-grandfathered Appeal Notice

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.

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 satisfied with the answers provided 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, investigational, not medically necessary or not 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 health care providers (your doctor, hospital, etc.)
- Availability of care or providers
- A decision not in your favor. This may include services that were denied, reduced or terminated. It also may include a slow response to a request.

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Appeal process overview

Here is a summary of the appeal process:

- **Step 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.
- **Step 2: Requesting a Level 2 Appeal**

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

Step 1: Filing a Level 1 Appeal with Priority Health

How do I file an 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. 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.

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 yourcase. 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. (see Step 2, Requesting 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 yet received the medical services you're filing an appeal for) Review must be completed with a final decision made within 30 calendar days after we receive your appeal and 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)Review must be completed with a final decision made within 60 calendar days after we receive your appeal and appeal forms. The 60 calendar days do not include any days you or your representative may delay the process.

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

Step 2: Requesting a Level 2 Appeal

If you disagree with the decision provided by the Appeal Committee, you may request an additional review, in writing. You can send your request to either Priority Health or your plan

administrator. You must submit your request for review in writing within 4 months of the date you received a response to your appeal.

Who reviews Level 2 appeals?
If your issue is about eligibility, payment of claims, payment or coordination of health care services or contracts with providers, your request will be reviewed by your employer.

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) Review must be completed with a final decision made within 30 calendar days after we receive your appeal and 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) Review must be completed with a final decision made within 60 calendar days after we receive your appeal and appeal forms. The 60 calendar days do not include any days you or your representative may delay the process.

Who reviews Level 2 appeals?
If your issue is a medical issue, your request may be reviewed by an Independent Review Organization (IRO).

Medical issues may include, but are not limited to:

- Requirements for medical necessity
- Appropriateness of care
- Health care setting
- Level of care
- Effectiveness of a covered benefit
- A decision that treatment is experimental or investigational

How long will it take for me to get an answer?
If your request qualifies, an independent review organization (IRO) will review your appeal. We'll tell you within 5 business days whether your request will be reviewed. If your appeal is medical, a doctor will review it. The IRO must make a decision within 45 days of receiving your external review request. The decision is binding.

What can I do if I'm still not satisfied with the decision?
If you're still not happy with a decision after completing these steps, you may file a civil suit under Sec. 502(a) of ERISA within 2 years of the date of service or coverage denial.

Priority Health expedited review (emergency review)

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

When can I ask for an expedited review?
The faster process will be followed when you file a request (verbally or in writing) when the normal time for an appeal would:

- put your life in danger
- interfere with your full recovery, or
- delay treatment for severe pain (must be confirmed by your doctor)

To request an expedited review over the phone, please call Customer Service at the number listed on the back of your ID card. During non-business hours, you can leave a message at 877.954.1035 (toll free) to make a request.

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 and excludes any delays by you or your representative.

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 2 business days after the decision.