

WHAT IF YOU DISAGREE WITH OUR DECISION?

In addition to the UM program, BCBSNC offers an appeals process for our MEMBERS. If you want to appeal an ADVERSE BENEFIT DETERMINATION or have a GRIEVANCE, you have the right to request that BCBSNC review the decision or GRIEVANCE through the appeals process. The appeals process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations). You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your PROVIDER of the decision. The type of ADVERSE BENEFIT DETERMINATION or GRIEVANCE will determine the steps that you will need to follow in the appeals process. For appeals relating to an ADVERSE BENEFIT DETERMINATION, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date indicated on your Explanation of Benefits.

Any request for review should include:

- SUBSCRIBER'S ID number
- SUBSCRIBER'S name
- Patient's name
- The nature of the appeal
- Any other information that may be helpful for the review.

To request a form to submit a request for review, visit our website at mybcbnsnc.com or call BCBSNC Customer Service at the number listed in "Who to Contact?"

All correspondence related to a request for a review through BCBSNC'S appeals process should be sent to:

Blue Cross Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702-3055

MEMBERS may also receive assistance with ADVERSE BENEFIT DETERMINATIONS and GRIEVANCES from Health Insurance Smart NC. To reach this Program, contact:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212

You may also receive assistance from the Employee Benefits Security Administration at 1-866-444-3272.

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the appeal, nor the subordinate of such

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individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Please forward written appeals to:

Magellan Behavioral Health
Appeals Department
PO Box 1619
Alpharetta, GA 30009

Second level appeal if eligible is provided by BCBSNC.

Quality of Care Complaints

For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.

First Level Appeal

BCBSNC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be evaluated by a North Carolina licensed medical doctor who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

If you are dissatisfied with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the appeals coordinator
- Availability of Health Insurance Smart NC including address and telephone number
- A statement of your rights, including the right to:

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- request and receive from us all information that applies to your appeal
- participate in the second level appeal meeting
- present your case to the review panel
- submit supporting material before and during the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
- pursue other voluntary alternative dispute resolution options as applicable.

The second level appeal meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level appeal. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your appeal even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting.

Notice of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level appeal or the second level appeal, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of this health benefit plan to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal.

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Information initially given by telephone must also be given in writing.

After requesting an expedited review, BCBSNC will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

External Review (Available only for NONCERTIFICATIONS)

Federal and state law provides for review of ADVERSE BENEFIT DETERMINATIONS by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. BCBSNC will notify you of your right to request an external review each time you receive:

- an ADVERSE BENEFIT DETERMINATION, or
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION, or
- a second level appeal decision upholding an ADVERSE BENEFIT DETERMINATION.

However, in order for your request to be eligible for an external review, the NCDOI must determine the following:

- your request is about a MEDICAL NECESSITY determination that resulted in an ADVERSE BENEFIT DETERMINATION (e.g. NONCERTIFICATION);
- you had coverage with BCBSNC when the ADVERSE BENEFIT DETERMINATION was issued;
- the service for which the ADVERSE BENEFIT DETERMINATION was issued appears to be a COVERED SERVICE; and
- you have exhausted BCBSNC's internal appeals process as described below.

For a standard external review, you will have exhausted the internal appeals process if you have:

- completed BCBSNC's first and second level appeals and received a written second level determination from BCBSNC, or
- filed a second level appeal and have not requested or agreed to a delay in the second level appeals process, but have not received BCBSNC's written decision within 60 days of the date you can show that the appeal was filed with BCBSNC, or
- received written notification that BCBSNC has agreed to waive the requirement to exhaust the internal appeal and/or second level appeals process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review

For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective ADVERSE BENEFIT DETERMINATION (an ADVERSE BENEFIT DETERMINATION which occurs after you have already received the services in question), the 60-day time limit for receiving BCBSNC's second level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeals process and have received a written second level determination from BCBSNC.

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Expedited External Review

An expedited external review may be available if the time required to complete either an expedited internal first or second level appeal or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- an ADVERSE BENEFIT DETERMINATION from BCBSNC and have filed a request with BCBSNC for an expedited first level appeal; or
- a first level appeal decision upholding an ADVERSE BENEFIT DETERMINATION and have filed a request with BCBSNC for an expedited second level appeal; or
- a second level appeal decision (also known as a final internal adverse benefit determination) from BCBSNC.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first level appeal or final internal adverse benefit determination of the admission, availability of care, continued stay or EMERGENCY health care services.

If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if you have exhausted the internal appeals process; or (2) require the completion of the internal appeals process and another request for an external review. An expedited external review is not available for retrospective (post-service) ADVERSE BENEFIT DETERMINATIONS.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review.

For further information or to request an external review, contact the NCDOI at:

(Mail)

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
(919) 807-6865
Fax: (919) 807-6865

(In person)

North Carolina Department of Insurance
Dobbs Building
430 N. Salisbury Street, 1st Floor, Suite 1018
1-866-444-3272
Tel: (toll free): 1-855-408-1212

(Web): www.ncdoi.com/Smart for external review information and request form

The Health Insurance Smart NC program provides consumer counseling on utilization review and appeals issues.

Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your PROVIDER of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BCBSNC upholding an ADVERSE BENEFIT DETERMINATION (generally the notice of a second level appeal decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BCBSNC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial ADVERSE BENEFIT DETERMINATION to the

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assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION or the second level appeal decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:

Blue Cross Blue Shield of North Carolina
Appeals Department
HQ2540HM
PO Box 30055
Durham, NC 27702-3055

Please note that you may also provide this additional information to the NCDOI within the seven-day deadline rather than sending it directly to the IRO and BCBSNC. The NCDOI will forward this information to the IRO and BCBSNC within two business days of receiving the additional information.

The IRO will send you written notice of its decision within 45 days (or, for an expedited review, within four business days) of the date the NCDOI received your external review request. If the IRO's decision is to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will, within three business days (or, for an expedited review, within one day) of receiving notice of the IRO's decision, reverse the ADVERSE BENEFIT DETERMINATION and provide coverage for the requested service or supply. If you are no longer covered by BCBSNC at the time BCBSNC receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, BCBSNC will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on BCBSNC and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same ADVERSE BENEFIT DETERMINATION for which you have already received an external review decision.