REVISED 02-01-2024

APPEALING A CLAIM

Claims Other Than Medical Necessity or Experimental/Investigational Services

This section describes the Greater Tompkins County Municipal Health Insurance Consortium (“GTCMHIC”) appeal process that applies to a claim denied, in whole or in part, for a reason other than a lack of medical necessity or the experimental/investigational nature of the service. (If a claim relates to medical necessity or the experimental/investigational nature of the service, please refer to the Section titled “Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure” for the applicable claim determination and appeal procedure.)

If a claim is denied in whole or in part, the covered person will receive notification of a claim denial via an explanation of benefits (EOB) form. The EOB form will be provided by the plan administrator, Excellus BlueCross BlueShield. The EOB will show the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for the consideration of the claim, the plan administrator will request it.

If a covered person does not agree with the denial of a claim, the covered person may follow the review steps outlined below:

Initial Contact or Inquiry:

The covered person may contact Excellus BlueCross BlueShield. by phone or by written correspondence to inquire as to the related contract or coverage provisions, the quality of the care, or to lodge a service complaint. The Customer Service Representative will initiate a review based on this contact and provide a response to the covered person. The covered person may contact Excellus BlueCross BlueShield. by calling the following numbers:

Excellus BlueCross BlueShield
1-877-253-4797

First Level of Review (Internal Appeal):

If the covered person is unable to resolve a contractual benefit or quality of care issue informally through the initial contact with a Customer Service Representative, the covered person or the covered person’s advocate may request a formal review of the case. A formal request for a review may be accepted from the covered person, the covered person’s designee, or the covered person’s medical provider via written correspondence within 180 calendar days of the covered person receiving the initial determination on the claim(s) in question. The inquiry will be researched by the appropriate personnel and a formal response will be provided to the covered person. The covered person may submit their internal appeal request for medical and pharmaceutical claims to Excellus BlueCross BlueShield at the following address:

Excellus BlueCross BlueShield
Customer Advocate Unit
PO Box 4717
Syracuse, NY 13221

Review by the Claims and Appeals Committee
If a covered person is not satisfied with an appeal determination regarding a claim that does not relate to a medical necessity or experimental/investigational services denial, the covered person may request a claim review by the GTCMHIC Claims and Appeals Committee by filing a written request for a review to the following address:

Greater Tompkins County Municipal Health Insurance Consortium
408 East Upland Road
Suite 2
Ithaca, NY 14850
Attn: Executive Director

Upon receipt of a written request, copies of all pertinent information will be gathered and presented to the GTCMHIC Claims and Appeals Committee. The covered person may also submit written opinions and/or any comments regarding the claim which will be included with the materials and information presented to the GTCMHIC Claims and Appeals Committee.

Requests for review by the GTCMHIC Appeals Committee should be filed promptly; however, requests may be filed at any time within 120 days of the final adverse determination by the plan administrator, Excellus BlueCross BlueShield.

The GTCMHIC Claims and Appeals Committee will render its decision within 60 days of the receipt of the written request for review, unless specific circumstances warrant an extension. The decision of the GTCMHIC Claims and Appeals Committee pertaining to the review will be delivered in writing to the covered person, stating the specific reasons for the decision and the specific reference to the pertinent plan provisions upon which the decision is based.

Arbitration
If the covered person and/or the covered person's labor organization is not satisfied with the decision of the GTCMHIC Claims and Appeals Committee; and if the labor organization determines that the claim is meritorious and further appeal is in the best interests of the labor organization, the labor organization may submit the claim to arbitration, the outcome of which will be binding on all parties. The cost of the arbitration shall be divided equally between the GTCMHIC and the labor organization. The voluntary rules of the American Arbitration Association will apply, and a mutually acceptable arbitrator competent in the field of medical claims arbitration will be used.

If a covered person is not in a recognized bargaining unit, the written request for arbitration must be submitted directly to the plan administrator from the covered person. In such a case, the cost of the arbitration will be divided equally between the Plan and the covered person.

A request for arbitration must be submitted, in writing, to the GTCMHIC Executive Director within 30 days of receipt of the written decision of the GTCMHIC Claims and Appeals Committee to the following address:

Greater Tompkins County Municipal Health Insurance Consortium
408 East Upland Road
Suite 2
Ithaca, NY 14850
Attn: Executive Director

Claims Related to Medical Necessity or Experimental/Investigational Services: Utilization Review Procedure

This section explains the utilization review (UR) procedure applicable to the Plan's decisions that relate to the medical necessity of care, including the appropriateness of the level of care or the provider of care; or to the experimental and/or investigational nature of care.

- Services will be deemed medically necessary only when all the following criteria are met:
    - Provide for the treatment or diagnosis of an illness or injury, including premature birth, congenital and other birth defects;
    - Necessary to meet a patient's basic health needs;
    - Appropriate for the symptoms, consistent with the diagnosis, and in accordance with generally accepted medical practice and professionally accepted standards;
    - Not recommended because it is more convenient for the patient, the physician, or other provider; and
    - The most appropriate method of providing safe and adequate care.

Confinement in a hospital or other facility is considered medically necessary when the covered person needs to be confined because of the nature of the services that the covered person requires, or when treatment for the covered person's condition would be considered unsafe or inadequate if performed on an outpatient basis.

Treatment that is educational or done primarily for research will not be considered medically necessary.

A benefit payment will not be made if the plan administrator determines that the service, care, or supply was not medically necessary. However, the Plan will pay benefits if directed to do so pursuant to an external appeal.

The fact that any particular physician or health care professional may prescribe, order, recommend, or approve service, supply or technology does not, in itself, make the services medically necessary.

The definition of medical necessity relates only to coverage and may differ from the way in which a provider engaged in the practice of medicine may define medical necessity.

Utilization Review Procedure
Given the voluntary nature of the Plan's managed care program, most of the UR procedures under this section including the pre-admission review process and the concurrent review process will not be applicable unless the covered person requests such a review.

UR decisions are made when a pre-admission review is requested for care (the "prospective review process"), a request is made for review of a case during the course of care (the "concurrent review process"), and after care is rendered (the "retrospective review process").

Examples of cases that would be reviewed under the UR procedure include a refusal of prior authorization for an inpatient hospital stay because the care is available on an outpatient basis; or a determination that a covered person can be released from a hospital because the covered person's condition no longer requires 24-hour nursing service; or a determination that the treatment received by a covered person is experimental and/or investigational, in light of the covered person's condition.

1. **PRE-ADMISSION REVIEW PROCESS**

a. All requests for pre-admission review of care are reviewed to determine medical necessity (including the appropriateness of the proposed level of care and/or provider) and to determine whether the care is experimental and/or investigational. The initial review is performed by a nurse. If the nurse determines that the proposed care is medically necessary and not experimental and/or investigational, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

b. Notice of an approval of proposed care or an adverse determination that proposed care is not medically necessary or is experimental and/or investigational will be provided to the covered person, a designee authorized in writing by the covered person (if any), and the provider, by telephone and in writing, within three (3) business days of the request. If additional information is needed, it will be requested within 3 business days. The covered person or the covered member's provider will then have 45 calendar days to submit the information. A notice of the determination will be provided to the covered person (or the covered member's designee) and the covered member's provider, by telephone and in writing within three (3) business days of the earlier of our receipt of the information or the end of the 45-day time period.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will also describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation, if any, needed to make an internal appeal determination.

d. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within three (3) business days from the date of reconsideration. All of the information described in paragraph 1.c. above will be included in this notice.

2. **CONCURRENT REVIEW PROCESS**

a. When a covered person is receiving services and requests a concurrent review, a nurse will assess the medical necessity and experimental and/or investigational nature of services received throughout the course of treatment.

b. Once a case is assigned for concurrent review, a nurse will determine whether the services being received are medically necessary and not experimental and/or investigational. If so, the nurse will authorize the care. If the nurse determines that the care is not medically necessary or is experimental and/or investigational; or that further evaluation is needed; the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). If additional information is needed, it will be requested within one (1) business day. The covered member or the covered member's provider will then have 45 calendar days to submit the information. Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

c. The covered member (or the covered member's designee) and the provider will be notified of the concurrent review decision, by telephone and in writing, within 1 business day of the earlier of the plan administrator's receipt of all information or documentation needed for the review or the end of the 45 day period.

e. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date services may begin, and the date of the next scheduled concurrent review of the case. If care is not authorized, the notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to a review of the adverse determination; give instructions for initiating standard, expedited, and external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

f. If, prior to making an adverse determination, no attempt was made to consult with the provider who requested the prior authorization, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. The reconsideration will take place within 1 business day of the request for reconsideration, in consultation with the requesting provider. If the adverse determination is upheld, notice will be given to the provider, by telephone and in writing, within 1 business day from the date of reconsideration. All of the information described in paragraph 2.d. above will be included in this notice.

3. **RETROSPECTIVE REVIEW PROCESS**

a. At the option of the plan administrator, a nurse will review retrospectively the medical necessity and the experimental and/or investigational nature of services, which are subject to utilization review. If the nurse determines that care received was medically necessary and not experimental and/or investigational, the nurse will authorize benefits. If the nurse determines that the care was not medically necessary or was experimental and/or investigational, the nurse will refer the case to a clinical peer reviewer (defined in paragraph 1.a. above). Failure to make a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be an adverse determination that is subject to internal appeal (described in paragraph 4. below).

b. The covered person, an authorized designee, and the provider will be notified of the retrospective review determination, in writing, within 30 calendar days from receipt of the claim by the plan administrator. If additional information is needed it will be requested within 30 calendar days. The covered member's or the covered member's provider will then have 45 calendar days to submit the information. A determination will be made and notice provided to the covered member and the covered member's provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

c. The notice of any adverse determination will include the reasons, including clinical rationale, for the determination. The notice will describe the right to request a review of the adverse determination; give instructions for initiating standard, expedited, or external appeals; and specify that a copy of the clinical review criteria used to make the adverse determination may be requested in writing. The notice will also specify additional information or documentation needed, if any, to make an internal appeal determination.

d. The provider who rendered care for which benefits are denied may request an internal appeal of the retrospective adverse determination on behalf of the covered person (even if not authorized in writing by the covered person to act as designee).

4. **REVIEW OF ADVERSE DETERMINATIONS**

a. ***Request for internal appeal***

i. The covered person, an authorized designee, and, in a retrospective review case, the health care provider may request an internal appeal of an adverse determination, verbally or in writing, within 180 days from the date that notice of the adverse determination is received. (If the notice received does not specify all information required to conduct an internal appeal, the time period for appealing will be extended.) To submit an internal appeal verbally, the covered person, an authorized designee, or the provider may call 1-877-253-4797. To submit a written internal appeal, the covered person, an authorized designee, or the provider may write to the plan administrator.

ii. The procedure that will be followed in reviewing a case will differ, depending upon the urgency of the case. In most cases, a standard internal appeal, described in paragraph b. below, will be appropriate. In "urgent cases," an expedited internal appeal is available; expedited internal appeal is described in paragraph c. below.

b. ***Standard internal appeal***

i. The plan administrator will acknowledge an internal appeal in writing, within 15 calendar days after receiving it. The acknowledgment will identify the plan administrator (including the address and telephone number) as the person designated to respond to the appeal.

ii. When one or more internal appeals are received (for example, the covered person submits an appeal, then the health care provider submits an appeal on behalf of the covered person), a single internal appeal will be conducted by a clinical peer reviewer (a physician who possesses a current and valid non-restricted license to practice medicine, or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition) who did not make the initial adverse determination.

iii. The clinical peer reviewer will render a determination within 45 calendar days after receipt of all necessary information. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Written notice of the determination will be provided to the covered person and any other qualified party submitting an internal appeal, within 2 business days after the determination is made. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

iv. The notice will include detailed reasons and the clinical rationale for the determination. If the determination is adverse, the notice will describe the process, and enclose an application, for requesting an external appeal of the adverse determination. The external appeal process is described in paragraph d. below.

c. ***Expedited/Urgent Internal Appeal***

i. For cases involving a prospective or concurrent (but not retrospective) review decision (such as the review of continued or extended health care services; additional services rendered in the course of continued treatment; or any other issue with respect to which a provider requests an immediate review), the covered person, an authorized designee, or the provider may request an expedited internal appeal of the initial adverse determination. For prospective reviews that involve urgent matters, the plan administrator will make a determination and provide notice to the covered member (or the covered member's designee) and the covered member's provider within 72 hours of the receipt of the request. For concurrent reviews that involve urgent matters, we will make a determination and provide notice to the covered member (or the covered member's designee) and the covered member's provider within 24 hours of receipt of the request if the request for additional benefits is made at least 24 hours prior to the end of the period to which benefits have been approved. Requests that are not made within this time period will be determined within the timeframes specified for prospective; pre-service claims.

ii. When a request for expedited internal appeal is received, the appeal will be conducted by a clinical peer reviewer (defined in subparagraph (b)(ii) above) who did not render the initial adverse determination. Reasonable access to the clinical peer reviewer assigned to the appeal will be provided within 1 business day following receipt of notice of the request for appeal, to ensure that all relevant information is available to the clinical peer reviewer. Upon request, the covered person's provider and the clinical peer reviewer may exchange information by telephone or fax. If additional information is needed, it will be requested within 24 hours of the appeal request. The covered member or the covered member's provider will then have 48 hours to submit the information.

iii. In regards to concurrent reviews for urgent matters, if the plan administrator has approved a course of treatment, the plan administrator will not reduce or terminate the approved services unless the plan administrator has given the covered member enough prior notice of the reduction or termination so that the covered member can complete the appeal process before the services are reduced or terminated.

iv. Within 24 hours of receipt by the plan administrator of all information needed for the appeal, the clinical peer reviewer will render a determination on the expedited internal appeal. If the determination is adverse, this will be the "final adverse determination" for purposes of the external appeal process described in paragraph d. below. Failure to render a determination within the time periods required by Article 49 of the New York Insurance Law will be deemed to be a reversal of the initial adverse determination.

v. Notice will be provided to the covered person, an authorized designee, and the provider, by telephone and in writing, within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period. The notice will include all of the information described and enclosed in a notice of standard internal appeal determination (see subparagraph b. iv. above) and will describe the right to a standard internal appeal following an adverse determination on expedited internal appeal. The covered person, an authorized designee, and, where appropriate, the provider will be advised that, if a standard internal appeal is requested after the expedited internal appeal, the standard internal appeal may take longer than the 45-day time frame for requesting an external appeal through New York State Department of Financial Services, which begins on the date of receipt of the final adverse determination notice upon completion of expedited internal appeal.

External appeal – The covered member's right to an External Appeal
In some cases, the covered member has a right to an external appeal of a denial of coverage. Specifically, if coverage is denied on the basis that a service does not meet the requirements for Medical Necessity including appropriateness, health care setting, level of care or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases). The covered person or the covered person's representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for the covered member to be eligible for an external appeal the covered member must meet the following two requirements:

- The service, procedure or treatment must otherwise be a Covered service under the Policy: and

- In general, the covered member must have received a final adverse determination through the Internal Appeals Process. But, the covered member can file an external appeal even though the covered member has not received a final adverse determination through the Internal Appeal process if:

    - It is agreed in writing that the internal appeal is waived. The Plan is not required to agree to the covered member's request to waive the internal appeal; or

    - The covered person files an external appeal at the same time as the covered person applies for an expedited internal appeal; or

    - The Plan fails to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to the covered member, and the Plan can demonstrate that the violation was for good cause or due to matters beyond the Plan's control and the violation occurred during an ongoing, good faith exchange of information between the parties).

A Covered Person's Right to Appeal a Determination that a Service is:

1. **Not Medically Necessary**
   If, coverage is denied on the basis that the service does not meet the requirements for medical Necessity, the covered member may appeal to an External Appeal Agent if the covered member meets the requirements for an external appeal outlined above.

2. **Experimental or Investigational**
   If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment, the covered person must satisfy the two requirements for an external appeal above and the covered person's attending Physician must certify that:

   a. The covered person's condition or disease is one for which standard health services are ineffective or medically inappropriate; **or**

   b. The covered person's condition or disease is one for which there does not exist a more beneficial standard service or procedure covered by us; **or**

   c. The covered person's condition or disease is one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, the covered person's attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the covered member than any standard Covered Service (only certain documents will be considered in support of this recommendation – The covered member's attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which the covered member is eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which the covered person's attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to the covered member than the requested service, the requested service is likely to benefit the covered member in the treatment of the covered member's rare disease, and such benefit out-weights the risk of the service. In addition, the covered members' attending Physician must certify that the covered member's condition is a rare disease that is currently or was previously subject to a research study by the Nation Institutes of Health Rare Disease Clinical Research network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, the covered person's attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat the covered person's condition or disease. In addition, for a rare disease treatment, the attending Physician may not be the covered member's treating Physician.

A Covered Person's right to Appeal a Determination that a Service is Out-of-Network
If the Plan has denied coverage of an Out-of-Network treatment because it is not materially different than the health service available In-Network, the covered member may appeal to an External Appeal Agent if the covered member meets the two requirements for an external appeal above, and the covered member requested preauthorization for the Out-of-Network treatment.

In addition, the covered member's attending Physician must certify that the Out-of-Network service is materially different from the alternate recommended In-Network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate In-Network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate In-network health service.

For purposes of this section, the covered person's attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat the covered person for the health service.

The covered person does not have the right to an external appeal for a denial of a Referral to an Out-of-Network provider on the basis that a health care provider is available In-network to provide the particular health service requested by the covered member.

The External Appeal Process

The covered person has four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an External Appeal. If the covered person is filing an external appeal based on the Plan's failure to adhere to claim processing requirements, the covered member has four (4) months from such failure to file a written request for an External Appeal.

The Plan Administrators will provide an external appeal application with the final adverse determination issued through the Internal Appeal process or the written waiver of an Internal Appeal. The covered person may also request an External Appeal application from the New York State Department of Financial Services at 1-800-342-3736. Submit the completed application to the Department of Financial services at the address indicated on the application. If the covered member meets the criteria for an External Appeal, the State will forward the request to a certified External Appeal Agent. ***Please note that although the Greater Tompkins County Municipal Health Insurance Consortium is a self-insured medical benefits plan it is a Certified Municipal Cooperative Health Benefit Plan pursuant to Article 47 of the New York State Insurance Law and as such follows the same external appeals process as an Article 43 not-for-profit insurance company.***

Under the No Surprises Act (NSA) a member may file an external appeal if issued a final adverse determination for any of the following reasons:

- The health plan determines that out-of-network emergency services received were non-emergent; or
- The health plan determines that the out-of-network services received do not qualify as a surprise bill; or
- Incorrect cost-sharing was applied to the member's bill for either emergency services or a surprise bill; or
- There is a question on whether the claim for out-of-network care you received was coded correctly by the provider and accurately reflects the treatment received, and the associated NSA protections related to cost sharing and surprise billing.

The covered person can submit additional documentation with the External Appeal request. If the External Appeal Agent determines that the information submitted represents a material change from the information on which the Plan based its denial, the External Appeal Agent will share this information with the Plan in order for the Plan to exercise its right to reconsider the Plan's decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm the decision. Please note that in the case of an expedited appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the covered person's completed application. The External Appeal Agent may request additional information from the covered person, the covered person's physician or the Plan. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the covered member in writing of its decision within two (2) business days.

If the covered member's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the covered person's health; or if the covered person's attending Physician certifies that the standard external appeal time frame would seriously jeopardize life, health or ability to regain maximum function; or if the covered member received emergency services and has not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, the covered member may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of the covered member's completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the covered member and the Plan by telephone or facsimile of that decision. The External Appeal Agent must also notify the covered person in writing of its decision.

If the External Appeal Agent overturns the Plan's decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment the Plan will provide coverage subject to the other terms and conditions of the covered person's plan. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to the covered member according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the covered member's plan for non-investigational treatment provided in the clinical trial.

The External Appeal Agent's decision is binding on both the covered member and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

The plan may charge the covered member a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. The Plan will waive the fee if it is determined that paying the fee would be a hardship to the covered member. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to the covered member.

The Covered Member's Responsibilities

It is the covered member's RESPONSIBILITY to start the external appeal process. The covered member may start the external appeal process by filing a completed application with the New York State Department of Financial Services. The covered member may appoint a representative to assist them with the covered member's application; however, the Department of Financial Services may contact the covered member and request that the covered member confirm in writing that the covered member has appointed the representative.

Under New York State law, a covered member's completed request for an external appeal must be filed within four (4) months of either the date upon which the covered member receives a final adverse determination, or the date upon which the covered member receives a written waiver of any Internal Appeal, or the Plan's failure to adhere to claim processing requirement. The Plan has no authority to extend this deadline.