

This section contains information about the member appeal process. Medical, hospital and dental provider appeals information is available in the Appeals for providers section of this manual.

### **Member Appeal Policy and Procedures**

Our Member Appeal Policy applies to all insured group and individual contracts issued by us except for the BlueCross BlueShield Federal Employee Program® (BCBS FEP®), Medicare beneficiaries, Medicaid and certain other government programs.

An appeal must be initially submitted to us within the timeframes noted below. Failure to initiate appeal within this time period (absent the Plan's finding, in its sole discretion, of acceptable extenuating circumstances) will preclude all further rights to appeal and may jeopardize the member's ability to contest the denial or other action in any forum. All applicable non-optional appeal levels must be exhausted before the member may contest the action in any forum, including through filing a lawsuit.

### **Joint Administration**

Appeals requested on behalf of joint administration members need to be submitted to AmeriBen; MagnaCare or Zenith American Solutions within 180 days of receipt of the written notification of an adverse benefit determination.

AmeriBen; MagnaCare or Zenith will send a copy of the written determination to the member and provider.

#### AmeriBen

Appeals requested on behalf of members for the following joint administration groups are handled by AmeriBen:

- Alpha Media (group #70000010)
- AlSCO Inc. (group #70000002)
- Avalon Health Care, Inc. (group #70000007)
- CHG Healthcare Services (group #70000004)
- CTI Foods (group #70000011)
- J-U-B Engineers, Inc. (group #70000009)
- The Terteling Company Inc. (group #70000015)

Appeals requested on behalf of members for the groups listed above should be submitted to:

AmeriBen  
Attention: Appeals Coordinator  
P.O. Box 7186  
Boise, ID 83707

## MagnaCare

Appeals requested on behalf of IAFF Health and Wellness Trust (IAFF HWT) (group #70000014) members are handled by MagnaCare:

MagnaCare  
Attention: Appeals  
P.O. Box 8085  
Garden City, NY 11530

## Zenith American Solution

Appeals requested on behalf of members of the following joint administration groups are handled by Zenith American Solutions:

- U.A. Local Union 290 Plumber, Steamfitter & Shipfitter Health Trust (U.A. Local Union 290) (group #70000003)
- UFCW Local 555-Employers Health Trust (group #70000005)

Appeals requested on behalf of members for the groups listed above should be submitted to:

### **Level 1 member appeals for U.A. Local 290 and all appeals for UFCW Local 555-Employers Health Trust:**

Zenith American Solutions  
Benefits and Claims department  
Attention: Appeals Coordinator  
12205 SW Tualatin Road, Suite 200  
Tualatin, OR 97062

### **Level 2 member appeals for U.A. Local 290:**

The Board of Trustees  
U.A. Union Local No. 290  
Plumber, Steamfitter and Shipfitter Industry  
Attention: Appeals Coordinator  
12205 SW Tualatin Road, Suite 200  
Tualatin, OR 97062

Provider appeals for joint administration members should be submitted to Regence following standard Regence guidelines.

## **Appeal Levels**

Self-funded plans establish their own appeal processes and some aspects of the appeal process required by the Affordable Care Act or state regulations may not apply to them. Please contact Customer Service for details.

## Level One Internal Appeal

The member or member's representative has the right to request an appeal within 180 days of receipt of the written notification of an adverse benefit determination. If a member chooses to file an appeal, they may appeal in writing or verbally by contacting Customer Service for assistance. Customer Service can provide the member with a form for a written appeal.

An appeals specialist will acknowledge receipt of the appeal and gather the necessary information to thoroughly investigate the issue. Level one appeals are reviewed by an employee or employees who were not involved in the initial decision. In appeals that involve issues requiring medical judgment, the decision is made by employees who are healthcare professionals.

Upon completion of the review, the appeals specialist will send a written response to the member. We attempt to respond to all appeals within 14 calendar days (self-funded plans may have different timeframes; investigational post-service issues are responded to within 20 working days; and other post-service issues are responded to within 30 calendar days).

If the decision is not in the member's favor, the member or member representative will be informed of their right to further appeal.

## Level Two Internal Appeal

When an additional internal level of appeal is available for the member's Plan, the member or member's representative may request a level two appeal within 180 days of receipt of the first level appeal decision.

Level two appeals are reviewed by an employee or employees who were not involved in, or subordinate to anyone involved in, the initial or the first-level decision.

We attempt to respond to preauthorization appeals within 15 calendar days and post-service appeals within 30 calendar days.

If the decision is not in the member's favor, our notification will include information about the right to request an external review by an Independent Review Organization (IRO).

## Voluntary External Appeal - IRO

The member or member's representative may submit a written request for external review to the Idaho Department of Insurance (DOI) within 4 months of receipt of the previous determination (self-funded plans may have different timeframes and processes). If the request is eligible, the DOI will assign it to an Independent Review Organization. We will deliver the appeal, including all documentation, to the IRO within 14 days of assignment.

An IRO is an independent organization employing physicians and other medically-qualified individuals or experts with appropriate clinical expertise, which acts as the decision maker for external appeals (regular or expedited), through assignment to the Plan via regulatory requirements. The IRO practitioner rendering the decision will not have been involved in the original Appeal determination. The IRO does not have any direct financial interest in the Plan or outcome of independent reviews.

The IRO will provide to the member and/or appeal representative, us, and the DOI, in writing:

- the decision by the IRO
- a full description of the IRO's rationale

The IRO's decision is binding.

### **Expedited (Urgent) Appeals**

An expedited appeal may be requested for urgent care requests if:

- the member or the member's physician reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent issue could seriously jeopardize life or health of the member or others, due to the member's psychological state, or the ability to regain maximum function, or
- a physician with knowledge of the member's medical condition reasonably believes that the application of time periods for making regular appeal determinations for a pre-service or concurrent care issue could subject the member to severe pain that cannot be adequately managed without the disputed care or treatment, or

concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

#### Internal Expedited Appeal

The member, their representative or the physician may request an expedited appeal either verbally or in writing. The member, provider or member representative may provide additional written documentation supporting the member's position. Expedited appeals are responded to within 72 hours from the receipt of the request. If the decision is not in the member's favor, the member or member's representative will be informed of their right to further appeal.

#### Voluntary External Expedited Appeal – IRO

If the member is dissatisfied with the outcome of the previous appeal, the member or member representative may request an external review by an Independent Review Organization by submitting a written request to the Idaho Department of Insurance (DOI). If the request is eligible, the DOI will assign it to an IRO. We will deliver the appeal, including all documentation, to the IRO within 14 days of assignment (self-funded plans may have different timeframes and processes).

An IRO is an independent organization employing physicians and other medically-qualified individuals or experts with appropriate clinical expertise, which acts as the decision maker for external appeals (regular or expedited), through assignment to the Plan via regulatory requirements. The IRO practitioner rendering the decision will not have been involved in the original Appeal determination. The IRO does not have any direct financial interest in the Plan or outcome of independent reviews.

The IRO will respond within 72 hours of their receipt of the request and will provide to the member and/or appeal representative, us, and the DOI, in writing:

- the decision by the IRO
- a full description of the IRO's rationale

The IRO's decision is binding.

A participating physician, can minimize complaints and appeals by:

- Acknowledging and upholding members' right to complaints, grievances and appeals
- Explaining these rights to members who express a concern or dissatisfaction
- Assisting us in timely resolution by submitting requested records or input within seven days of the request

## Definitions

"Appeal" includes any grievance, complaint, reconsideration or similar terms as used in some jurisdictions, and is a written or oral request from a member, their personal representative, treating provider or appeal representative, to change a previous decision (Adverse Benefit Determination) made by us concerning:

- access to health care benefits, including an adverse determination made pursuant to utilization review;
- claims payment, handling or reimbursement for health care services;
- matters pertaining to the contractual relationship between a member and the Plan; or
- other matters as specifically required by law or regulation.

"Appeal representative" is a representative of the member for the purpose of the appeal. The appeal representative may be the member's treating provider, personal representative, or another party, such as a family member, for whom the member or their personal representative has signed a valid authorization. If we do not receive an authorization, we will only disclose the determination and any personal information to the member, their personal representative or treating provider.

"Personal representative" means a person who is legally authorized to act on behalf of an individual for health care decisions. For example: parents of a minor; a person holding a power of attorney; conservator; or person appointed by a court; so long as the power granted to the person includes managing the individual's health care affairs.

"Authorization" is an individual's written permission for use and disclosure of their personal information for a specific purpose and timeframe in accordance with our privacy policy. **Note:** *Authorization to Disclose Protected Health Information* forms are available on our member website, **regence.com**: Resources/Forms-documents.

"Adverse benefits determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- eligibility to participate in a plan

- application of utilization review
- determination that a treatment is experimental or investigational
- determination that a treatment is not medically necessary or
- contractual exclusion or limitation

## **Member Rights and Responsibilities**

We are committed to providing our members with the best possible health care coverage. Members are entitled to be treated in a manner that respects their rights and addresses their responsibilities.

Providing the best possible health care coverage requires more than comprehensive benefit packages, prompt claims processing and efficient customer service. It also includes notifying our members of their rights and responsibilities and conscientiously protecting these rights. Therefore, we have developed a written policy that addresses members' rights and responsibilities. This policy is revised based on regulatory requirements for entities such as: Centers for Medicare & Medicaid Services (CMS) and Federal and State Patient Protection Acts.

Everyone within the health plan is responsible for protecting these rights. Our participating physicians, other health care professionals and facilities are also contractually obligated to preserve and respect these rights.

### Rights for members enrolled in our plans

Subscribers and their enrolled dependents have the right to make their own health care decisions. Although we must set guidelines that affect how benefits are paid, these guidelines merely dictate whether the cost of care is eligible for reimbursement.

Our members have the right to:

#### Timely and quality care

- timely access to their physicians and other health care professionals and referrals to specialists when medically necessary
- continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care
- receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury
- have their physicians and health care professionals tell them about their diagnosis, the prognosis of their condition, and instructions required for follow-up care
- participate with physicians and health care professionals in decision-making regarding their health care and treatment planning
- a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

#### Treatment with dignity and respect

- not be discriminated against and be treated with respect, dignity, compassion and the right to privacy
- exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or

educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect these rights by both the Plan and contracting physicians.

- expect consideration of privacy concerning their care and confidentiality in all communications and in their medical records
- extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care
- know why they are given various tests, treatments or procedures, who provides them, and the risks of any procedure or treatment
- refuse treatment and to be informed of the medical consequences of this action
- refuse to sign a consent form if they feel they do not clearly understand its purpose, or cross out any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent
- be informed of policies regarding Advance Directives (living wills) as required by state and federal laws

#### Health plan and other important information

- receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and member rights and responsibilities statements
- expect a clear explanation regarding benefits and exclusions of their policy
- know by name the physicians, nurses, or other health care professionals providing care
- information about medications – what they are, how to take them and possible side effects
- information regarding how medical treatment decisions are made by the health plan or contracted medical groups, including payment structure
- be advised if a practitioner proposes to engage in experimentation affecting care or treatment. They have the right to refuse or participate in such research projects

#### Solving problems in a timely fashion

- present questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed
- voice a complaint about their health plan or the care provided including the right to appeal an action or a denial, and the process involved
- make recommendations regarding the health plan members' rights and responsibilities policies

#### Responsibilities for members enrolled in our plans

In addition to their rights, subscribers and their enrolled dependents have the responsibility to:

- identify themselves as our enrollee and present their identification card when requesting health care services
- be on time for appointments and contact the physician or other health care professional at once if there is a need to cancel or if they are going to be late for an appointment; if the physician, other health care professional or facility has a

policy for assessing charges regarding late cancellations or “no shows,” they will be responsible for such charges

- provide, to the extent possible, information about their health to physicians and other health care professionals so they may provide appropriate care
- do their part to improve their health condition by following the plans, instructions, and care that they agreed upon with the physician or health care professional
- act in a manner that supports the care provided to other patients and the general functioning of the office or facility
- to participate, to the degree possible, in understanding their behavioral health problems and developing mutually agreed upon treatment goals
- review their employee benefit booklet to make sure services are covered under the plan
- follow Plan requirements to have services properly authorized before receiving medical attention
- to participate, to the degree possible, in understanding their health problems including behavioral health, and developing mutually agreed upon treatment goals
- inform Customer Service if they feel they or their family members are not receiving adequate care
- check their benefit booklet and follow proper procedures for illness after business hours
- review information and materials concerning health benefits and educate other covered family members
- provide identification cards to family members to be presented at the time of service
- accept the financial responsibility for any co-payment or coinsurance associated with services received while under the care of a physician or other health care professional or while a patient at a facility
- let us know if they have concerns, or if they feel their rights are being compromised so we may act on their behalf