MID-AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

MID-AMERICA ASSOCIATES, INC.

APPEAL PROCEDURES - CLAIM APPEAL

When Your claim is denied, first try to resolve the matter by calling the Administrator available from 8:00 – 4:30 Monday through Friday. Usually the Administrator can provide You with details and Plan Document language supporting the determination of Your claim. When needed, Your claim will be referred for further review.

You have 180 days from the initial adverse determination to file an appeal. Failure to do so will cause the loss of Your appeal rights. Except for an Urgent Care Claim appeal, written appeals are required for all Pre-Service and Post-Service claims. Pre-Service or Post-Service appeals will not be accepted by telephone.

ADVERSE BENEFIT DETERMINATIONS: Is a denial, or a failure to provide or make payment in whole or in part for a benefit. This includes denials based on eligibility, application of utilization review and/or Medical Necessity. If an adverse determination occurs, You will receive a statement explaining the reasons.

WHAT IS AN APPEAL?

"Appeal" means a complaint on behalf of You or a covered dependent submitted by You or a person authorized in writing to act on Your behalf regarding:

a. The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made under utilization review.
b. Benefits or claims payment, handling, or reimbursement for health care services.
c. Matters pertaining to the contractual relationship between You and us.
d. Rescission of coverage whether or not the rescission has affected any benefit at the time.

This does not apply to a provider's complaint about claims payment, handling, or reimbursement for health care services.

WHO CAN FILE AN APPEAL

You may file an appeal. If elected, You may authorize a representative to pursue a claim or appeal. You must notify the Administrator in writing advising the name of the person authorized to act on Your behalf. This requirement does not apply to family members, the member's legal guardian or a legislative representative. You must appoint all others, including agents and health care providers in writing. To assign your appeal rights to your healthcare provider, supplier or other representative; complete and return the Transfer of Appeal Rights form available on our website at: www.maaassociates.com.

An assignment of benefits by You does not appoint the health care provider as Your authorized representative.

Authorization to Obtain and Release Medical Information: You can help expedite the review by returning the completed authorization form with Your appeal. This form is necessary to obtain medical information relevant to Your appeal. The form includes a separate release allowing the Administrator to share information with an Independent Review Organization (IRO) should You request an External Review. The Administrator will not release medical information to anyone else.

Internal Review: The Appeal Committee will review the appeal and provide You with a written determination. To assure a fair review, the Appeal Committee assigned to Your appeal will not include those involved in the initial adverse determination.

Exception for Urgent Care Claims: The Administrator must without regard to procedures for identifying authorized representatives; permit a health care professional to act as Your authorized representative. This exception is to allow a health care professional with knowledge of Your medical condition to pursue a claim on Your behalf. The Administrator will permit this if You cannot act on Your own behalf.

AUTHORIZATION FOR DESIGNATED REPRESENTATIVE forms are available on the Administrator's website at www.maaassociates.com or contact by phone at 1-800-482-0945.

TIME LIMITATIONS FOR DETERMINATIONS

URGENT CARE CLAIMS: The Administrator will respond within 72 hours of receiving the request for review or sooner .If additional information is requested, You must provide information within 48 hours of the request.
An Urgent Care Claim is any claim for care or treatment that the time allowed for a non-urgent appeal could seriously jeopardize Your life, Your ability to regain maximum function; or in the opinion of Your Physician would subject You to severe pain that cannot be adequately managed without the care or treatment. **Urgent Care Appeals are accepted by telephone.**

PRE-SERVICE CLAIMS: The Administrator will respond within 15 days of receiving the request for review.
A Pre-Service Claim requires Prior-Authorization or Pre-Certification by the Plan. The benefit Plan lists procedures that require Prior-Authorization and/or Pre-Certification for benefit payment. **Appeals for Pre-Service Claims must be in writing.**

A claim that does not require Prior-Authorization or Pre-Certification by the Plan is not a Pre-Service Claim.

POST-SERVICE CLAIMS: The Administrator will respond within 30 days of receiving the request for review.

A Post-Service Claim is any claim that is not a Pre-Service claim. Post-Service claims are claims that do not require Plan approval before You obtain medical services. It is a claim submitted for payment for medical care already received by You. A Post-Service claim never constitutes a claim involving urgent care. **Appeals for Post-Service Claims must be filed in writing.**

NORMAL APPEAL PROCEDURES – You have 180 days from the initial adverse determination to file First and Second Level Appeals

You may initiate a normal appeal after Your attempt to resolve the matter with Customer Service has failed. To begin the appeal process You must take these steps.

Appeal First Level Review: Send a written complaint explaining why You disagree with the adverse determination. Mail, fax or email the complaint:

Attention: Susan LaFreniere
Appeal Committee
Mid-America Associates, Inc.
P.O. Box 5047
Troy, MI 48007

Fax: (248) 583-4647
Phone: (248) 585-7900 x 1645
Email: sl@maaassociates.com

The Administrator will make a determination in writing within 30 calendar days for a Post- Service Claim; 15 days for Pre-Service Claim after You submit an appeal in writing. The time the Administrator must respond includes no period of time You must provide Administrator additional information. It further does not include the time since You have received the final determination but have not taken further action. An extension may apply for a period of time that shall not exceed 10 business days if he Administrator has not received information from a health care facility or health professional.

Appeal Second Level Review: You have the right to a Second Level Appeal.

You may present the Second Level Appeal in writing or by pre-arranged conference call. Conference call will include You, person assigned to represent You and the Appeal Committee. To schedule an Appeal conference call, contact the Administrator at (800) 482-0945 x 1645. The Administrator will provide the final determination in writing to You within 30 days for a Post-Service Claim or 15 days for a Pre-Service Claim. If submitting Second Level Appeal in writing, please indicate “Second Level Appeal” on the top of Your written complaint. You will be granted an additional 30 days to file a Second Level Appeal if the 180 days was exhausted on the First Level Appeal. The additional 30 days begins on the date You receive the First Level Appeal adverse benefit determination.

If after the 30-day period, the Administrator has not responded or You are not satisfied with the determination, You may request an External Review by an Independent Review Organization (IRO).

EXPEDITED INTERNAL APPEAL PROCEDURE FOR URGENT CARE CLAIMS

Request an Expedited Appeal if Your health can be acutely jeopardized by the time allowed for a normal appeal. Your Physician must substantiate the severity of Your need either orally or in writing to the Administrator. Call or fax request for an Expedited Appeal.

Expedited Appeals Committee
Attention: Susan LaFreniere
Mid-America Associates, Inc.
P.O. Box 5047
Troy, MI 48007 Telephone: 1-800-482-0945 x 1645 Fax: (248) 583-4647

The Administrator will make a determination within 72-hours after receipt of an Expedited Internal Appeal. You will be provided written notice of the determination within 2-business days if the determination was provided orally.

If you have a condition, where the time frame for completing an Expedited Internal Appeal would seriously jeopardize Your life or health or would jeopardize the ability to regain maximum function, You may file a request for an Expedited External Review at the same time You file the Expedited Internal Appeal.

You can authorize another person, including but not limited to a Physician, to represent You throughout the appeal process. You must authorize this designation in writing to the Administrator.

Within 10 days of Our final determination, You may request an Expedited External Review by an independent review organization (IRO) as permitted under the Patient's Right To Independent Review Act. This request must be made within 10 days after You receive the adverse determination. You may make this request if You satisfy two conditions.

1. You have already requested an Expedited Internal Appeal review.
2. The time allowed for an expedited internal review could seriously jeopardize Your health or Your ability to regain maximum function. Your Physician must substantiate this to the Administrator.

Expedited External Reviews are available for claims that involve (1) medical judgment (including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (2) a rescission of coverage (whether or not the rescission affects any benefit at the time).

The Administrator will assign an IRO when Your request is accepted for Expedited External Review. The assigned IRO shall be accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO will provide notice of the external review decision within 72 hours after the date the request and all information is received. If notice is provided verbally, the IRO will provide written notice within 48 hours. . This notice will be provided to You or Your authorized representative and the Administrator. The decision by the IRO is final. If the IRO reverses the adverse benefit determination, the Plan will pay benefits per the Plan Document.

For further information about Expedited External Review or the Patient's Right to Independent Review Act, contact Customer Service at: 1-800-482-0945.

EXTERNAL REVIEW PROCEDURES

You cannot request an External Review until You exhausted the internal appeals process.

You have the right for an External Review by an IRO as permitted under the Patient's Right to Independent Review Act. You can request an External Review after You have exhausted all levels of the internal appeals process, or if the Administrator fails to issue a written decision within 30 days after receiving Your formal appeal. You must make this request within 4 months of receiving Your final determination.

You must complete the HIPAA Authorization To Release Confidential Medical Information for this External Review.

For questions on how to file an External Review, contact.

Susan LaFreniere
Appeal Committee
P.O. Box 5047
Troy, MI 48007

Fax: (248) 583-4647
Phone: (248) 585-7900 x 1645
E-mail: sl@maaassociates.com

You will receive notice within 5-business days if Your request is eligible for an External Review. The Administrator will assign an IRO when Your request for External Review is accepted. If Your request is not eligible for an External Review, the Administrator will provide notice within one business day providing the reasons Your request is not eligible. If Your request is not complete, the Administrator will notify You of the missing information and allow You to complete the request for external review providing Your complete request is received within four months after the date You received the final internal adverse benefit determination.

When accepted, the assigned IRO shall be accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO will provide notice of the external review acceptance to You and advise You to submit in writing all additional information that the IRO must consider when conducting the external review. The Administrator will submit all documents and information used to make the final internal adverse benefit determination within 5 business days after the IRO is assigned. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. This written notice will be provided to You and the Administrator. The decision by the IRO is final. If the IRO reverses the adverse benefit determination, the Plan will pay benefits per the Plan Document.

For further information about External Review or the Patient's Right to Independent Review Act call us at: 1-800-482-0945.

External and Expedited review decisions made by independent review organizations are final. You cannot file a subsequent request for External Review involving the same issue You already received a decision on under the Patient's Right to Independent Review Act.

Other Resources to Help You

If Your claim is denied or you have questions about Your rights, this notice, or for assistance, You can contact the Employee Benefits Security Administration at 1-800-444-3272. You may also seek other remedies available under federal or state law.

HIPAA Authorization To Release Confidential Medical Information

Recipient: MID-AMERICA ASSOCIATES, INC.

NAME OF MEMBER:_____ MEMBER ID:_____

PATIENT NAME:_____ DATE OF BIRTH:_____ GROUP NUMBER_____

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("Provider") that has provided payment, treatment, consultation, advice or services to or on behalf of myself (or the person whom I represent) as listed above ("Insured") to disclose the entire medical record, prescription history, medications prescribed and any other protected health information about the Member to Mid-America Associates, Inc., its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) Infection and information on the diagnosis and treatment of mental illness and substance abuse (excluding psychotherapy notes).

I acknowledge by my signature below, that I agree and authorize any Provider to release and disclose the entire medical record without restriction.

The purpose of this disclosure is to evaluate my application for health care coverage or claim for benefits made so Mid-America Associates, Inc. may:

1) Administer coverage, review appeal or determine eligibility.
2) Underwrite an application for life insurance coverage; make eligibility, Policy/Plan issuance or enrollment determinations.
3) Administer claims and determine responsibility for coverage and provisions of benefits.
4) Validate enrollment application statements.

This authorization shall be effective immediately and remain in force for 12 months following the date of my signature below. A copy of this authorization is as valid as the original. By providing written notification to Mid-America Associates, Inc., I may revoke this authorization at any time. A revocation is not effective if a Provider has already relied on this Authorization to disclose information about the Member or if Mid-America Associates, Inc. has a legal right to contest a claim under a Plan, an insurance Policy or to contest the Policy/Plan itself. Any information disclosed under this authorization is no longer covered by federal rules governing privacy and confidentiality of health information. Mid-America Associates Inc. will not re-disclose except as authorized by me or as required under law.

Providers may not refuse to treat or provide health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Mid-America Associates may not process an application for insurance/health coverage, or if coverage has been issued, may make no benefit determinations, appeal determinations or payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE

1._____ _____
Signature of Patient or Authorized Representative Date

Protected Health Disclosure Authorization

My signature below acknowledges and authorizes Mid-America Associates, Inc. to disclose pertinent protected health information to the assigned Independent Review Organization to conduct an External Review.

2._____ _____

MID AMERICA
EMPLOYEE BENEFIT ADMINISTRATION

TRANSFER OF APPEAL RIGHTS

You have the right to appeal if all or a portion of your claim is denied. You may transfer you appeal rights to your healthcare provider, supplier or assign a personal representative to appeal on your behalf. For additional information, refer to "APPEAL PRECEDURES – CLAIM APPEAL" attached.

The transfer of appeal rights does not extend beyond the service(s) or issue identified below. This transfer is permanent unless you cancel it. You may at any time during the appeal process, terminate the transfer of appeal rights by contacting our office at 800-482-0945 or by fax at (248) 583-4647.

Whether or not you choose to transfer your appeal rights, you are financially responsible for your cost-share and all charges related to the denied claim expense.

To Transfer Appeal Rights – Fully Complete and return this form by fax at (248) 583-4647, email: sl@maaassociates.com, or by mail: Mid-America Associates, Inc. PO Box 5047 Troy, MI 48007.

NAME OF EMPLOYEE:_____ MEMBER ID:_____

EMPLOYEE PHONE NUMBER:_____ EMAIL:_____

PATIENT NAME:_____ GROUP NUMBER:_____

ADDRESS OF EMPLOYEE:_____
Street City State Zip

DATE(S) OF SERVICE:_____

PROVIDER/SUPPLIER:_____

DESCRIBE TYPE OF SERVICE AND/OR SUPPLIES:_____

_____

- *Below must be completed and signed by the patient over age 18 or the employee representing the dependent under age 18*

I _____, voluntarily transfer my claim appeal right to_____ _____. _____who is: _____Provider/Supplier, or if other than the Provider//Supplier name of person_____describe relationship:_____.
I understand that I will have no right to appeal a denied claim for this item or service unless I cancel the transfer of appeal rights in writing. I understand this transfer of appeal rights is valid for only the date(s) of service, item or issue described below:

DATE(S) OF SERVICE:_____

PROVIDER/SUPPLIER:_____

DESCRIBE TYPE OF SERVICE AND/OR SUPPLIES:_____

_____

_____ _____
Signature of Patient (if over age 18) otherwise signature of Employee Date

Whether I assign my appeal rights or not, I understand that I have a maximum of 180-days from the date of the denial determination to appeal my claim. Assigning my rights does not extend my time limit to appeal.