sidecar health

Notice of Adverse Benefit Determination

HEALTH PLAN ADMINISTRATOR: Sidecar Health Insurance Company	**TELEPHONE:** 855-346-4846 **FAX:** 866-376-2053
MAILING ADDRESS: 440 N Barranca AVE #7028, Covina, CA 91723	**EMAIL ADDRESS:** grievances@sidecarhealth.com **WEBSITE ADDRESS:** www.sidecarhealth.com

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION THAT YOU SHOULD RETAIN FOR YOUR RECORDS

This document is provided to you because of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision we make to not fully pay for an item or service. This could be because the charge for the item or service exceeds the specified Benefit Amount. We may also make a decision to not pay for an item or service if we determine it is not medically necessary, or you are not eligible for the benefit, or the benefit is not covered under your plan. You may have the right to an appeal if you think a decision to not fully pay for an item or service was made in error (see the Important Information About Your Appeal Rights section of this notice).

Important Information about Your Appeal Rights

What if I need help understanding this denial? If you need assistance understanding this notice or our decision to deny you a service or coverage, please contact us at:

Phone Number: 855-346-4846

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

What if I don't agree with this decision? You have a right to appeal any decision to decline to provide or pay for any item or service (in whole or in part).

How do I file an appeal? Complete the Appeal Request Form, keep a copy for yourself and send the form to us at any of the following addresses:

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

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Notice of Adverse Benefit Determination

Please see the “Other resources to help you” section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent as shown below, your review will generally be conducted within 72 hours. An urgent situation is one in which your health or life may be in serious jeopardy, you may not be able to regain maximum function if treatment is delayed or, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by checking the appropriate box on the Appeal Request Form. If your treating physician believes you will require a Concurrent Expedited Internal Appeal and Expedited External Review due to your urgent medical condition or a proposed experimental or investigational treatment that must begin promptly, please check the appropriate box on the Appeal Request Form. Your doctor must complete the Treating Physician Certification Form for Internal Appeal and/or External Review to verify your situation.

Who may file an appeal? You, someone you name or someone who is authorized by law to act for you (your authorized representative) may file an appeal. Please complete the Appointment of Authorized Representative section of the Appeal Request Form.

Can I provide additional information about my claim? Yes, you may supply additional information. Please forward your information to any of the following addresses:

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at:

Phone Number: 855-346-4846

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

What happens next? If you request an appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage or service requested

or you do not receive a decision within 30 days, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Please refer to the attached External Review Procedures Summary for more information.

Other resources to help you:

For questions about your rights, this notice, or for further assistance you may contact:

Employee Benefits Security Administration, U.S. Department of Labor
(866)-444-3272
200 Constitution Ave., NW
Washington, DC 20210
http://www.askebsa.dol.gov

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Request for Internal Appeal

Name of person filing appeal: _____

Relationship to covered person: ❒Covered Person/Applicant

❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Covered Person/Applicant Information

Name: ID Number:

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

Internal Appeal Specifications

1. Are you requesting an expedited appeal because your health, life or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal? ❒YES ❒NO

2. Are you requesting an expedited appeal because your physician certifies that your pain can not be controlled while you wait up to 30 days for a decision on your appeal?
   ❒YES* ❒NO

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Request for Internal Appeal

3. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review and your physician certifies that it is necessary? *(Note: Request for External Review form is not required.)* ❒YES* ■NO

*If you answer YES to question 2 or 3 above, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review. You may also have your physician complete the certification form if you answer YES to question 1.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an appeal. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider, and/or health plan issuer to release all relevant medical or treatment records to an independent review organization, and/or my health plan. I understand that the independent review organization and/or my health plan will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

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Request for Internal Appeal

Signature of Covered Person (or legal representative**) Date

***Parent, Guardian, Conservator or Other - please specify*

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 866-376-2053

Email Address: grievances@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination and all documents and correspondence related to this claim.

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External Review Request Form

Name of person filing request for external review: _____

Relationship to covered person: ❒Covered Person/Applicant

❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Covered Person/Applicant Information

Name: ID Number:

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?
   ❒YES ❒NO

If you answer yes, your physician must complete the Treating Physician Certification Form for Internal Appeal and/or External Review.

2. Is your requested healthcare service considered an experimental or investigational treatment?
   ❒YES ❒NO

If you answer yes, your physician must complete the Treating Physician Certification for Experimental/Investigational Adverse Benefit Determinations.

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External Review Request Form

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time. I hereby authorize _____ to pursue my external review on my behalf.

_____

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider and/or health plan to release all relevant medical or treatment records to the independent review organization. I understand that the independent review organization will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative**) Date

**Parent, Guardian, Conservator or Other - please specify*

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 866-376-2053

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External Review Request Form

Email Address: grievances@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination and all documents and correspondence related to this claim.

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Request for Expedited Appeal Certification

Note to the Treating Physician

Covered Persons may request an internal appeal and/or external review when a health plan issuer has denied a healthcare service or course of treatment. The standard internal appeal and external review processes can take up to 30 days from the request date to the date a decision is rendered. Expedited appeals or reviews are only available under the circumstances shown below. This form is for the purpose of providing the certification necessary to obtain an expedited appeal or review. Please complete the General Information section along with the appropriate certification and return the executed form to Sidecar Health Insurance Solutions at any of the addresses shown below:

Fax Number: 866-376-2053

Email Address: grievances@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

General Information

Name of Covered Person/Patient:

Covered Person's Health Plan ID Number:

Name of Treating Physician:

Licensure and Area of Clinical Specialty:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

Expedited Internal Appeal Certification

I hereby certify that I am a treating physician for the Covered Person / Patient listed above (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.

Treating Physician Printed Name:

_____

Signature Date

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Request for Expedited Appeal Certification

Concurrent Expedited Internal Appeal and Expedited External Review Certification

I hereby certify that I am a treating physician for the Covered Person / Patient listed above (hereafter referred to as “the covered person”); and (select all that apply):

❒ that adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function; and that, for this reason, the covered person’s expedited internal appeal should be conducted simultaneously with an expedited external review.

❒ that the recommended experimental or investigational treatment would, in my professional judgment, be significantly less effective if not promptly initiated; and that, for this reason, the covered person’s expedited internal appeal should be conducted simultaneously with an expedited external review. I have attached the completed Treating Physician Certification Form for Experimental/ Investigational Adverse Benefit Determinations.

Treating Physician Printed Name:

_____

Signature Date

Expedited External Review Certification

I hereby certify that I am a treating physician for the Covered Person / Patient listed above (hereafter referred to as “the covered person”); that adherence to the time frame for conducting a standard external review would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function; and that, for this reason, the covered person’s external review should be processed on an expedited basis.

Treating Physician Printed Name:

_____

Signature Date

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Certification of Review for Experimental or Investigational Treatment

Note to the Treating Physician

Covered Persons may request an external review when a health plan issuer has denied a healthcare service or course of treatment that is considered experimental or investigational and is NOT explicitly listed as an excluded benefit under the covered person's health benefit plan. This form is for the purpose of providing the certification necessary to obtain a review. Please complete the entire form including the certification and return the executed form to Sidecar Health Insurance Solutions at any address shown below.

Fax Number: 866-376-2053

Email Address: grievances@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

General Information

Name of Covered Person/Patient:

Covered Person's Health Plan ID Number:

Name of Treating Physician:

Licensure and Area of Clinical Specialty:

Mailing Address:	Phone Number:
Email Address:	Fax Number:
Contact Person:	Phone Number:

I hereby certify that I am a treating physician for the Covered Person/Patient listed above (hereafter referred to as "the covered person"); and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health plan issuer's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

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Certification of Review for Experimental or Investigational Treatment

In my medical opinion as the covered person's treating physician, I hereby certify to the following: (Please check all that apply)

❒Standard healthcare services have not been effective in improving the condition of the covered person

❒Standard healthcare services are not medically appropriate for the covered person

❒There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service

Please provide a description of the recommended or requested healthcare service or treatment that is the subject of the adverse benefit determination. Please include any documentation that will be beneficial to the review process. Please attach additional sheets as necessary.

_____

_____

_____

_____

Treating Physician Printed Name:

_____

Signature Date

If you do not have your Benefit Card or you are not yet a member, we can help. (Please contact Member Care above).

If you, or someone you're helping, have questions about Sidecar Health, you have the right to get help and information in your language at no cost. Please call the Member Care number on your Benefit Card.

ARABIC

إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص Sidecar Health، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، ُرجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

CHINESE

如果您或者您在帮助的人对 Sidecar Health 存有疑问，您有权免费获得 以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请拨 打您的会员 ID 卡上的会员服务电话号码。

CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan Sidecar Health irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatiif bilbilaa.

DUTCH

Als u, of iemand die u helpt, vragen heeft over Sidecar Health, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

FRENCH (CANADA)

Des questions au sujet de Sidecar Health? Vous ou la personne
que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu Sidecar Health haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Servicenummer auf Ihrer Mitglieder-ID-Karte an

ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su Sidecar Health, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

JAPANESE

ご本人様、または身の回りの方で、Sidecar Health に関するご質問が ございましたら、ご希望の言語でサポートを受けたり、情報を入手 したりすることができます(無償)。 通訳をご利用の場合は、お 持ちの会員IDカードにある、会員サービスの電話番号までお問い合 わせ下さい。

KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 Sidecar Health에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Sidecar Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix.
Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-653-6440.

RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно Sidecar Health, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre Sidecar Health, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо Sidecar Health, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về Sidecar Health, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

Notice of Non-Discrimination

Sidecar Health complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. Sidecar Health does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Sidecar Health provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, Sidecar Health provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call the Member Care number on your Benefit Card.

If you believe that Sidecar Health has failed to provide the above-mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

Sidecar Health
Attn: Civil Rights Coordinator
440 N Barranca AVE #7028
Covina, CA 91723

1-877-653-6440

grievances@sidecarhealth.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.