

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: grievances@sidecarhealth.com

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

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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

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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.

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

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

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.

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.

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

فيحق لك الحصول على مساعدة ومعلومات مجاناً وباللغة التي تتحدث بها Sidecar Health إذا كان لديك، أو لدى أي شخص تساعد، أية استفسارات بخصوص. للتحدث إلى أحد المترجمين الفوريين، رُجى 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-Service Nummer 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 helpscht, 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 alstubleift 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>.