sidecar health

Notice of Adverse Benefit Determination

HEALTH PLAN ISSUER: Sidecar Health Insurance Company	**WEBSITE ADDRESS:** www.sidecarhealth.com

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

This document contains information on your rights in the event 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 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).

How To Contact Us

If you need assistance understanding this notice or any decision of ours regarding a claim, please message us through the Sidecar Health Member Portal or contact us at:

Fax Number	Phone Number	Mailing Address
866-376-2053	855-346-4846	440 N Barranca Ave # 7028, Covina, CA 91723

Important Information about Your Appeal Rights

Where can I find an explanation of my claim? Each claim has its own Expense Detail Page within the Member Portal. In the Expense Detail Page, you can view a summary of each item or service included in the claim.

Can I provide additional information about my claim? Yes, you may supply additional information by messaging us through the Sidecar Health Member Portal or sending your information to us by fax or mail, with Attn: Claims.

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 any of the methods listed above.

What if I don't agree with a claim decision? You have a right to appeal any decision of ours to not fully pay the provider charge for an item or service.

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How do I file an appeal? Complete the Appeal Request Form, keep a copy for yourself and either fax the form to us or mail the form to us, with Attn: Grievances.

Who may file an appeal? You, someone you authorize, 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.

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:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Complaint.mvc/DisplayConsumerComplaintForm
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

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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 ❒Member Inbox ❒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:

Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

Fax Number:

Contact Person: Phone Number:

Internal Appeal Specifications

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):

_____

_____

_____

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Request for Internal Appeal

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, the Ohio Department of Insurance, and/or my health plan issuer. I understand that the independent review organization, the Ohio Department of Insurance, and/or my health plan issuer 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.

_____

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

Mailing Address: Attn: Grievances, 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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Understanding the External Review Process

All health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. An adverse benefit determination is a decision by the health plan issuer not to provide benefits because they believe services are not medically necessary, or not covered, excluded, or limited under the plan, or they believe the covered person is not eligible to receive the benefit. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance.

A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information
- The adverse benefit determination indicates the requested service is experimental or investigational, and the treating physician certifies at least one of the following:
    - 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
    - No available standard healthcare service covered by the health plan issuer is more beneficial than the requested healthcare service

A covered person is entitled to an external review by the Ohio Department of Insurance in either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or any medical information
- The adverse benefit determination indicates that emergency medical services did not meet the definition of emergency AND the health plan issuer's decision has already been upheld through an external review by an IRO

All Reviews Retrospective. This Plan does not require prior authorization. All claims are adjudicated retrospectively. No expedited review is available for Adverse Benefit Determinations made after receipt of the healthcare service or services in question.

Request for External Review

- The covered person must request an external review within 180 days of the date of the notice of final adverse benefit determination issued by their health plan issuer.

Understanding the External Review Process

- All requests must be in writing and either faxed to 866-376-2053 or mailed to Attn: Grievances, 440 N Barranca Ave #7028, Covina, CA 91723.
- If the request is complete the health plan issuer will initiate the external review and notify the covered person in writing that the request is complete and eligible for external review.
    - The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information
    - The notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review
- The health plan issuer will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).
- If the request is not complete the health plan issuer will inform the covered person in writing and specify what information is needed to make the request complete.
- If the health plan issuer determines that the adverse benefit determination is not eligible for external review, the health plan issuer must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.
- The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the health plan issuer and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

- The Ohio Department of Insurance maintains a secure web based system that is used to manage and monitor the external review process.
- When a health plan issuer initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio accredited IRO that is qualified to conduct the review based on the type of healthcare service.
- The health plan issuer and the IRO are automatically notified of the assignment.

IRO Review and Decision

- The IRO must forward, upon receipt, any additional information it receives from the covered person to the health plan issuer. At any time the health plan issuer may reconsider its adverse benefit determination and provide coverage for the healthcare service. Reconsideration will not delay or terminate the external review. If the health plan issuer reverses the adverse benefit

determination, they must notify the covered person, the assigned IRO and the Ohio Department of Insurance within one day of the decision. Upon receipt of the notice of reversal by the health plan issuer, the IRO will terminate the review.

- In addition to all documents and information considered by the health plan issuer in making the adverse benefit determination, the IRO must consider things such as: the covered person's medical records, the attending healthcare professional's recommendation, consulting reports from appropriate healthcare professionals, the terms of coverage under the health benefit plan and the most appropriate practice guidelines.

- The IRO will provide a written notice of its decision within 30 days of receipt by the health plan issuer of a request for review. This notice will be sent to the covered person, the health plan issuer and the Ohio Department of Insurance and must include the following information.

    - A general description of the reason for the request for external review
    - The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review
    - The dates over which the external review was conducted
    - The date on which the independent review organization's decision was made
    - The rationale for its decision
    - References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

Binding Nature of External Review Decision

- An external review decision is binding on the health plan issuer except to the extent the health plan issuer has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law.

- A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to the health plan issuer.

If You Have Questions About Your Rights or Need Assistance You may contact:

Ohio Department of Insurance ATTN:
Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Complaint.mvc/DisplayConsumerComplaintForm
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

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Request for External Review

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 ❒Member Inbox ❒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:

Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

Email Address: Fax Number:

Phone Number:

External Review Specifications

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.

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):

_____

_____

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Request for External Review

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 issuer to release all relevant medical or treatment records to the independent review organization and/or the Ohio Department of Insurance. I understand that the independent review organization and the Ohio Department of Insurance 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

Mailing Address: Attn: Grievances, 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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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 the address shown below.

Fax Number: 866-376-2053

Mailing Address: Attn: Grievances, 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, 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، 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-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

You can file a grievance by mail or fax. 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.