**Internal Appeal Information – BHP Managed Plans**

BHP complies with all regulatory guidelines and responsibilities as established in MN statute 62M.06. BHP contracted managed health plans are responsible for informing all enrollees of the right to an appeal in their member communication materials.

Upon request and free of charge, you have the right to receive copies of the following by contacting BHP: Relevant information used to make this determination, and the internal rule, guidelines, or protocol that was relied upon in making this determination, if any.

**Continued Coverage**

BHP allows for members to have continued coverage under their medical benefit pending the outcome of an internal appeal. This applies only to concurrent care decisions if BHP has approved an ongoing course of treatment and any denial, reduction or termination of such course of treatment before the end of such period of time or number of treatments. This does not apply to requests for extension of the course of treatment beyond the already approved period or number.

**Internal Appeal Rights – PreferredOne Self-Funded Plans**

If *your* request or claim is wholly or partially denied, reduced, or terminated based on medical judgment, *you* may have a right to have such decision reviewed by a physician who did not make the initial determination not to certify.

1. **Standard Internal Appeal** If *your* request for pre-certification of non-acute care services is wholly or partially denied and *you* have not received such non-acute care services, or if *you* are currently receiving non-acute care services and a request for the continuation of these services is wholly or partially denied, *you or your* authorized representative (appointed family member, treating practitioner, appointed attorney, etc) may submit an appeal within 180 calendar days after receiving notice that *your* request is denied. *Your* appeal can be submitted to BHP in writing, along with any issues, comments, and additional information, as appropriate.

Within 30 calendar days after your appeal request is received by BHP, *you* will receive notice of BHP’s decision, including the specific reasons for it and references to the part of the *Plan* on which it is based, and the procedure for requesting an external appeal from the *Plan Administrator (PreferredOne)*. This time period may be extended if *you* agree.

Your group benefit plan is governed by the Employee Retirement Income Security Act of 1974 (“ERISA”), you have the right to bring a civil action under Section 502(a) ERISA, if you receive an adverse determination after all appeal reviews required by your plan have been completed.

The level of benefits provided will be determined by the terms and conditions of the benefit plan language. All benefits and final payment determinations are made at the time of claims submission.

1. **Expedited Internal Appeal** *You* may request an expedited internal review if:
2. The initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal. BHP allows for members and the attending health care processional to appeal the determination over the telephone as expeditiously as the member’s medical condition requires, but no later than 72 hours after receiving the expedited appeal.