

Carrum Health Benefit Claims and Appeals

Initial Claims and Denials under the Carrum Health Benefit

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/pebp, or by downloading the 'Carrum Health' app on iPhone and Android devices to search for and compare participating Centers of Excellence. After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. To receive coverage under the Carrum Health Benefit, services must be scheduled and authorized by Carrum Health.

Participants are required to agree to Carrum Health's Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to their selected Center of Excellence as needed to schedule a consultative evaluation. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion.

In the case of a failure by a participant (or the participant's authorized representative) to follow the Plan's procedures for requesting authorization to participate in the Carrum Health Benefit, the participant or representative shall be notified of the failure and the proper procedures to be followed. This notification shall be provided to the participant or authorized representative, as appropriate, as soon as possible, but not later than five days following the failure. Notification may be oral, unless written notification is requested by the participant or authorized representative.

Coverage under the Carrum Health Benefit may be denied, in whole or in part, by Carrum Health in the following circumstances:

Refusal to complete required documentation

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's request to participate in the Carrum Health Benefit if the participant has failed to submit any documentation that must be submitted to approve participation in the Carrum Health Benefit. The participant will be given additional time, without a deadline, to submit those forms. If the participant responds without providing the required documentation, Carrum Health will notify the participant that requested participation in the Carrum Health Benefit has been denied within 15 days after receipt by Carrum Health of the participant's response.

Request for referral to another Center of Excellence

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant requests to be referred to another Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral is to an outpatient facility or ambulatory surgical center (ASC) that cannot treat the participant because their condition is too complex, in which case the participant may be referred to an acute care Center of Excellence. This also does not apply when the consulting COE agrees surgery is necessary, however there are medically related circumstances prohibiting the member from utilizing the initial COE. In this case the participant may be referred to one alternative Center of Excellence.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of learning of the participant's request that this request has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The Treatment is Being Sought to Satisfy a Court Order

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant's treatment is sought for purposes of satisfying a court order.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Violation of Terms of Service or Member Registration Agreement

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant violates the Carrum Health Terms of Service or Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Participant does not provide written approval from their probation officer that they are allowed to travel for treatment.

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant on probation does not provide written approval from their probation officer to travel to an out of state COE to obtain treatment.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due

to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Benefit Notifications

Carrum Health will provide a participant with written or electronic notification of any adverse benefit determination. The notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the appeal procedures and the time limits applicable to such procedures, including a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination of a second-level appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Appeals

The Plan requires two levels of appeal with respect to the Carrum Health Benefit. The request for a first-level appeal must be made within 180 days following receipt of the adverse benefit determination, by submitting such request to Carrum Health at appeals@carrumhealth.com. The request for a second-level appeal must be made within 60 days following receipt of the adverse benefit determination on review, by submitting such request to Carrum Health at appeals@carrumhealth.com.

As part of the appeal process, a participant may submit written comments, documents, records, and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is

neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

A participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits.

A participant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by Carrum Health in connection with the claim or any new or additional rationale for an adverse benefit determination as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the participant a reasonable opportunity to respond prior to that date.

When the requested treatment has not yet been provided, Carrum Health will notify the participant of a benefit determination on review no later than 15 days after receipt by Carrum Health of the participant's request for a first-level appeal or second-level appeal, as applicable. When requested treatment has already been provided, Carrum Health will notify the participant of benefit determination on review no later than 30 days after receipt by Carrum Health of the participant's request for a first-level appeal or a second-level appeal, as applicable.

Carrum Health will provide a participant with written or electronic notification of an appeal determination. In the case of an adverse benefit determination, the notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- A statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination of a second-level appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

No action at law or in equity may be brought to recover under the Carrum Health Benefit under the Plan until all administrative remedies have been exhausted (including the two levels of appeal). If a participant fails to file a timely claim, or if the participant fails to request a review in accordance with the Plan's claim procedures outlined

herein, such participant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

Any action at law or in equity with respect to any and all claims relating to the Carrum Health Benefit under the Plan must be brought for recovery within one year from the earlier of (1) the date of an adverse benefit determination on a second-level appeal, if applicable, or (2) the accrual of any claim under or relating to the Carrum Health Benefit that does not result in an adverse benefit determination on a second-level appeal.