Employee Section

Underwriter Documents

avēsis

Coolidge Unified School District #21
11000-237
927

☐ I am Waiving Vision Insurance

AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Avesis Insurance Incorporated Kansas City, Missouri

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth	*Social Security Number*	*Sex*
/ /	- -	☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code*
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.
I certify that I am eligible to participate and that the above information is correct.

Signature	*Date* / /

AIIENRF AII-AVP1

By signing above, I understand that I must remain enrolled during the Benefit Plan period.

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ☐ Dependents	☐ **Change** ☐ Address ☐ Name ☐ Phone ☐ COBRA	☐ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)

Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____

Requested Effective Date / /	*Date of Employment* / /

AVĒSIS INSURANCE INCORPORATED
10400 N. 25th Avenue, Suite #200, Phoenix, AZ 85021 ** (800) 522-0258

Group Insurance Certificate Providing Limited Benefits for Vision Care Non-Participating

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance - This Certificate explains the plan of insurance which is underwritten by Avēsis Insurance Incorporated. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing Your Group Number and Your Effective Date.

Important Notice - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

DEFINITIONS

The following terms have specific meaning as used in the Policy.

Covered Person means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Covered Person will also include Your Dependents, if enrolled.

Dependent means any of the following persons: 1) Your lawful spouse; 2) Each unmarried child from birth to age 19 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption, and child under Your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 15 or more hours weekly for six or more months.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder on the face of the Policy.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing Optician.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

Vision Materials means corrective lenses and/or frames or contact lenses.

We, Our, Us means Avēsis Insurance Incorporated.

You, Your, Yours means the employee covered under the Policy.

DEFINITIONS
(PPO and Non-PPO)

Preferred Agreement means an agreement between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

Non-Preferred Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

Preferred Provider means a Provider who has signed a Preferred Agreement with the PPO.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

PPO Service Area means the geographical area where the PPO is located.

EFFECTIVE DATES

Effective Date of Employee's Insurance - Your insurance will be effective as follows: 1) If the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) If the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible, provided; a) You have given Us Your enrollment form (if required) on, prior to, or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) If You fail to meet the requirements (a) and (b) within 30 days after becoming eligible, Your coverage will not become effective until We have verified that You have met these requirements. You will then be advised of Your effective date.

Effective Date of Dependent's Insurance - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

Newborn Children - If a Dependent is covered under Your Certificate, a Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

Adopted Children - If a Dependent child is placed with You for adoption while the Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	Preferred Provider	Non-Preferred Provider (Up to a Maximum Dollar Amount of):	Benefit Period
Vision Examination:	$10.00 copayment	$35.00	12 Months
Vision Materials:	$10.00 copayment	N/A	
Standard Lenses			12 Months
Single	Paid in full after copayment	$25.00	
Bifocal	Paid in full after copayment	$40.00	
Trifocal	Paid in full after copayment	$50.00	
Lenticular	Paid in full after copayment	$80.00	
Standard Progressives	$50.00	$40.00	
Frames	$50.00	$45.00	12 Months
*Contact Lenses**			12 Months
Elective	$130.00	$130.00	
Medically Necessary	Paid in full	$250.00	

**Contact Lenses* includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Examination is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Vision Examination Benefit - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; or 8) Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

TERMINATION OF INSURANCE

For all Covered Persons - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The end of the last period for which any required contribution agreed to in writing has been made; c) The date You are no longer eligible for insurance; d) The date Your employment with the Employer ends. Your coverage will end on the last day of the month in which employment ends. The Employer may, at its option, continue insurance for individuals whose employment has ended, if it: (i) does so without individual selection between employees; and (ii) if it continues making premium payments for those individuals.

For Dependents - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

We may ask for proof of the eligible child's incapacity and dependency two (2) months before the date the Dependent would otherwise cease to be covered.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date We request proof which is not given to Us.

CLAIMS

Notice Of Claim. Written notice of claim must be given: (a) within 30 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

Proof Of Loss. Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

Time Of Payment Of Claims. Immediately after receiving written proof of loss, the Company will pay all benefits then due a Covered Person. If the claim is not paid within 30 days after the receipt of due written proof of loss, interest is paid from the date the claim is received by the Company.

Payment Of Claims. All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage whom We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

Legal Actions. No legal actions may be brought to recover under the Policy: (1) within 60 days after written proof of loss has been furnished as required; or (2) after three years (five years in Kansas and six years in South Carolina) from when written proof of loss is required.

Claim Appeal Procedure. If We partially or fully deny a claim for benefits submitted by a Covered Person and he or she disagrees or does not understand the reasons for this denial, the Covered Person may appeal this decision, and they have the right to: 1) Request a review of the denial; 2) Review pertinent plan documents; and 3) Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

The Covered Person's appeal must be submitted in writing within 180 days of receiving written notice of denial. We will review all information and send written notification within 60 days of the Covered Person's request.

GENERAL PROVISIONS

Entire Contract. The Policy is a legal contract. It is between the Policyholder and Us. The entire contract consists of: (1) the Policy, the Certificate, endorsements and attachments, if any; (2) the Policyholder's Application; and (3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by a Covered Person in an application will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished to the Covered Person.

Modification Of Policy. The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premiums, fraudulent misstatements or material misrepresentations after it has been in force for two (2) years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two (2) years. No statement, except fraudulent misstatements, made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

Fraud. If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

Misstatement Of Age. If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If a Covered Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Covered Person will be refunded.

Assignment Of Benefits. You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Grace Period. A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

AVĒSIS INSURANCE INCORPORATED

President

Secretary

AVESIS INSURANCE INCORPORATED

10400 N. 25th Avenue, Suite #200

Phoenix, Arizona 85021

Hereinafter called: Avesis

Health Care Insurer Appeals Process Information Packet
Avesis Insurance Incorporated

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process
Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call 1-800-648-8624 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602-364-2499 or 1-800-325-2548 or call us at 1-800-648-8624.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 100 N. 15th Avenue, Phoenix, AZ 85007-2624.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

	Expedited Appeals (for urgently needed services you have not yet received)	**Standard Appeals** (for non-urgent services or denied claims)
Level 1	Expedited Medical Review	Informal Reconsideration
Level 2	Expedited Appeal	Form Appeal
Level 3	Expedited External Independent Medical Review	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review (Level 1)

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us,
- We denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name:	Lori Henry
Title:	Director Data Integrity
Address:	Avesis Third Party Administrators, Inc.
	10400 N. 25th Avenue, Suite #200
	Phoenix, AZ 85021
Phone:	800-522-0258
FAX:	602-240-9100

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2, Expedited Appeal.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3, Expedited External, Independent Review: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Expedited Appeal (Level 2)

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider ***must immediately*** send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider hasn't already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3, Expedited External, Independent Review: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Expedited External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External, Independent Review. Send your request and any more supporting information to:

Name:	Lori Henry
Title:	Director Data Integrity
Address:	Avesis Third Party Administrators, Inc.
	10400 N. 25th Avenue, Suite #200
	Phoenix, AZ 85021
Phone:	800-522-0258
FAX:	602-240-9100

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract Coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgment of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; a copy of your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external IRO.

Within 5 business days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgment of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; a copy of your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. The OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Informal Reconsideration (Level 1)

Your request: You may obtain Informal Reconsideration of your denied request for a service or claim if:

- You have coverage with us,
- We denied your request for a covered service or claim,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request to:

Name:	Lori Henry
Title:	Director Data Integrity
Address:	Avesis Third Party Administrators, Inc.
	10400 N. 25th Avenue, Suite #200
	Phoenix, AZ 85021
Phone:	800-522-0258
FAX:	602-240-9100

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal, Level 2.

Our acknowledgment: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2.
If we grant your request: The decision will authorize the service or pay the claim and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Formal Appeal (Level 2)

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name:	Lori Henry
Title:	Director Data Integrity
Address:	Avesis Third Party Administrators, Inc.
	10400 N. 25th Avenue, Suite #200
	Phoenix, AZ 85021
Phone:	800-522-0258
FAX:	602-240-9100

Our acknowledgment: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 60 days to appeal to Level 3, External, Independent Review.
If we grant your request: We will authorize the service or pay the claim and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

External, Independent Review (Level 3)

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have 60 days after you receive our Level 2 decision to send us your written request for External, Independent Review. Send your request and any more supporting information to:

Name:	Lori Henry
Title:	Director Data Integrity
Address:	Avesis Third Party Administrators, Inc.
	10400 N. 25th Avenue, Suite #200
	Phoenix, AZ 85021
Phone:	800-522-0258
FAX:	602-240-9100

Neither you nor your treating provider is responsible for the cost of any External, Independent Review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical Necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside IRO, procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract Coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgment of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; a copy of your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeals levels.

Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external IRO.

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgment of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; a copy of your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the OAH. If we disagree with the Director's determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of the insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the OAH.
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Send to:	Name:	Avesis Insurance Incorporated	Phone:	800-522-0258
	Title:	Appeals Department	Fax:	855-691-3243
	Address:	10400 N. 25th Ave, Suite #200, Phoenix, AZ 85021		

Insured Member's Name	Member I.D. #	
Name of Representative Pursuing Appeal (if different from above)		
Mailing Address	Phone #	
City	State	Zip Code
Type of Denial: ☐ Denied Claim ☐ Denied Service Not Yet Received	Name of Insurer that denied the claim/service:	

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

_____

_____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

_____

_____

_____

_____

_____

_____

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or Avesis Insurance Incorporated at (800) 522-0258.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: ☐ Medical records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)
** Also attach the certification from your treating provider if you are seeking an expedited review.

► _____ _____

Signature of insured or authorized representative Date

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

Send to:	Name:	Lori Henry	Phone:	800-522-0258
	Title:	Director, Data Integrity	Fax:	602-240-9100
	Address:	Avesis Third Party Administrators, Inc.		
		10400 N. 25th Avenue, Suite #200, Phoenix, AZ 85021		

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider		
Phone #	Fax #	
Address		
City	State	Zip Code

PATIENT INFORMATION

Patient's Name	Member I.D. #	
Phone #		
Address		
City	State	Zip Code

INSURER INFORMATION

Insurer Name		
Phone #	FAX #	
Address		
City	State	Zip Code

- Is the appeal for a service that the patient has already received? ☐ Yes ☐ No
  If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.
  If "No," continue with this form.
- What service denial is the patient appealing? _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

Attach additional sheets if needed, and include: ☐ Medical records ☐ Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548. You may also call Avesis Third Party Administrators, Inc. at 800-522-0258.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

► _____ _____

Provider's Signature Date

N-EXP REV

AVESIS INSURANCE INCORPORATED

10400 N. 25th Avenue, Suite #200

Phoenix, Arizona 85021

Hereinafter called: Avesis

AMENDMENT RIDER

By attachment of this Rider, the Policy/Certificate is amended by the following:

Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

AVESIS INSURANCE INCORPORATED

Secretary President

AVESIS INSURANCE INCORPORATED

10400 N. 25th Avenue, Suite #200

Phoenix, Arizona 85021

Hereinafter called: Avesis

NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Avesis Insurance Incorporated has, by agreement, arranged for Avesis Third Party Administrators, Inc. to provide administrative services for your insurance plan. As administrator, Avesis Third Party Administrators, Inc. may be authorized to market, underwrite, bill and collect premiums, process claims payment, and perform other services, according to the terms of its agreement with the insurance company. Avesis Third Party Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Avesis Insurance Incorporated is liable for the funds to pay your insurance claims.

If Avesis Third Party Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against Avesis Third Party Administrators, Inc. than would otherwise be afforded to you by law.

AVESIS INSURANCE INCORPORATED

10400 N. 25th Avenue, Suite #200
Phoenix, Arizona 85021

Hereinafter called: Avesis

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we protect personal health information we have about you which relates to our medical, dental, vision and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; medical information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past, present or future payment for providing health care to you.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give You this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2013 or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our Insureds at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Your PHI

In conducting our business we will create records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

Treatment: We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

Payment: We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain payments and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, to operate our business. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We would also need to obtain your prior written authorization if your PHI were to be used for marketing or sales purposes.

To Your Family and Friends: We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care.

Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Health Plan: We may disclose your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Underwriting: We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose your PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB, Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice. We are also prohibited from using genetic information for underwriting.

Public Benefit: We may use or disclose your PHI without your authorization when required or permitted by law for the following purposes deemed in the public interest or benefit:

- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health and safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Business Associates: Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we disclose only the minimum information necessary for these business associates to perform their responsibilities, and we require them to appropriately safeguard the privacy of your information.

Individual Rights

Access: In most cases, you have the right to inspect and/or obtain an electronic or hard copy of the PHI that we maintain about you. You may also send a written request designating another individual to receive your PHI on your behalf. Written requests must be signed and dated by you or your personal representative using the "Contact Information" provided at the end of this Notice. The request must clearly identify the individual to receive your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations or as otherwise authorized by you during the six years prior to the date the accounting is requested. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the "Contact Information" provided at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Restriction: You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Unauthorized Access: You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Amendment: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Contact Information: If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Contact Office: Avesis Insurance Incorporated HIPAA Customer Service
Telephone: 800-522-0258 Fax: 866-650-2881
Address: 10400 N. 25th Avenue, Suite #200, Phoenix, Arizona 85021