Preface

This booklet summarizes and describes the provisions of the Lantern Surgery Care benefit offering ("Lantern Surgery Care"). Lantern Surgery Care is a supplemental medical benefit offering administered by Lantern Specialty Care. The medical benefits associated with the Lantern Surgery Care offering are benefits provided under UMR. Lantern Surgery Care is made available to members enrolled in coverage in UMR. These benefits are not insured by Lantern Specialty Care. As part of the Lantern Surgery Care offering, Lantern Specialty Care will provide certain administrative services related to your medical benefits, but covered benefits will be paid by UMR. The effective date of benefits through Lantern Surgery Care is January 1, 2025.

This booklet describes your rights and obligations, what benefits are covered, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this booklet. This booklet replaces and supersedes all prior documents describing coverage for the medical benefits associated with the Lantern Surgery Care offering that you may previously have received.

We encourage you to read this summary carefully and share it with your family members. If you have any questions about this booklet or your Lantern Surgery Care benefits, please contact the administrator of the Lantern Surgery Care benefits, Lantern Specialty Care, directly at (855)-200-2099 or the IMA Financial Group benefits department at HRBenefits@imacorp.com.

Separate summaries describing other benefits available under UMR are available to you and may be obtained by contacting the HR Benefits Department at HRBenefits@imacorp.com.

Participation in Lantern Surgery Care Benefits

Who Is Eligible for Lantern Surgery Care

If you are eligible for coverage under the IMA Financial Group UMR health plan, you are eligible for coverage through Lantern Surgery Care. For details relating to your eligibility for coverage through the UMR health plan, please refer to your applicable UMR health plan documents, available at: www.myimabenefits.com.

Enrollment in Lantern Surgery Care

Lantern Surgery Care is included with enrollment in the UMR health plan. You do not need to make a separate election to receive coverage through Lantern Surgery Care. You cannot elect coverage only through Lantern Surgery Care. For details relating to enrollment for coverage in the UMR health plan (for example, how to enroll, when coverage begins, and making enrollment changes during the year), please refer to your applicable UMR health plan documents, available at: www.myimabenefits.com

When Lantern Surgery Care Coverage Ends

In general, coverage under Lantern Surgery Care will end when your UMR health plan coverage ends. For details relating to when your UMR health plan coverage ends, as well as information regarding continuation of coverage (pursuant to COBRA or otherwise), please refer to your applicable UMR health plan documents, available at: www.myimabenefits.com

Lantern Surgery Care Benefits

Overview

The Lantern Surgery Care benefit is a comprehensive surgical program designed to provide you with covered benefits through a high-quality network of credentialed surgeons and facilities. Additionally, you will receive a concierge experience from a team of Care Advocates. The goal of Lantern Surgery Care is to simplify the surgical process from start to finish – from helping you select a qualified surgeon to scheduling appointments and assisting with medical bills related to certain aspects of your care. Lantern Surgery Care credentialed surgeons undergo a rigorous evaluation process to ensure that you receive high quality care from specialists who excel in the area related to your needs. By using the Lantern Surgery Care benefit, you may also save money through reduced member cost-sharing.

Covered Service Categories

Lantern Surgery Care specializes in covering non-emergent surgical events in the following surgical specializations:

Orthopedic Surgery (Joint)	**Orthopedic Surgery (Other)**	**Cardiac Surgery**	**Otolaryngology (Ear, Nose, and Throat)**
Most common procedures: • Knee Replacement/ Revision • Hip Replacement/Revision • Shoulder Replacement/ Revision • Ankle Replacement/ Revision • Elbow Replacement/ Revision • Wrist Replacement/ Revision	Most common procedures: • Joint Arthroscopy • Ligament Repair • Rotator Cuff Repair • Bunionectomy • Carpal Tunnel Release	Most common procedures: • Defibrillator Implant • Pacemaker Implant • Pacemaker Replacement • Valve Surgery • Cardiac Ablation	Most common procedures: • Ear Tube Insertion • Ear Infection • Septoplasty • Sinuplasty
Spine Surgery	**Genitourinary Surgery (GYN)**	**General Surgery**	**Interventional Pain Management**
Most common procedures: • Laminectomy • Laminotomy • Lumbar Interbody Fusion • Cervical Disk Fusion • 360 Spinal Fusion • Artificial Disk Replacement	Most common procedures: • Hysterectomy • Hysteroscopy • Myomectomy • Bladder Repair • Ovary Removal	Most common procedures: • Hernia Repair (inguinal, ventral, umbilical, or hiatal) • Laparoscopic Cholecystectomy • Thyroidectomy • Excision of Mass/ Biopsy	Most common procedures: • Cervical Epidural • Lumbar Epidural Steroid • Stellate Ganglion Block Epidural Blood Patch
Gastroenterology (GI)			
Most common procedures: • Colonoscopy • Endoscopy			

Lantern Surgery Care Provider Network

Providers affiliated with Lantern Surgery Care follow a pricing agreement to provide health care services and supplies to Participants at negotiated rates and are referred to in this SPD as "Lantern Surgery Care Providers". Lantern Surgery Care Providers include the physicians, other licensed health care practitioners, hospitals, and healthcare facilities, and collectively, they are referred to in this SPD as the "Lantern Surgery Care Network". The Lantern Surgery Care Network is separate from the provider network associated with your UMR health plan, although Lantern Surgery Care Providers may also participate such other provider network.

Optional Benefits Through Lantern Surgery Care

With the exception of Exclusive Lantern Surgery Care Procedures (defined in the "Exclusive Benefits Through Lantern Surgery Care" section below), utilization of Lantern Surgery Care is voluntary. In other words, with the exception of Exclusive Lantern Surgery Care Procedures, you also have the choice to access licensed providers, hospitals, and facilities outside the Lantern Surgery Care Network for covered benefits. However, any services received from providers outside of the Lantern Surgery Care Network will not be covered through Lantern Surgery Care under this SPD. Such services provided by providers outside of the Lantern Surgery Care Network may be covered under your UMR health plan, but coverage of those services would be subject to the applicable deductibles, coinsurance, and other terms applicable to your health plan, and you would not be eligible to receive the reduced cost-sharing associated with the Lantern Surgery Care benefit (for example, reduced copays, deductibles, and coinsurance applicable to coverage through Lantern Surgery Care). If electing not to utilize Lantern Surgery Care for a surgical procedure, you should refer to the plan documents related to your UMR health plan.

Exclusive Benefits Through Lantern Surgery Care

The Lantern Surgery Care benefit is the exclusive source of coverage for the Bariatric Surgery and Orthopedic (Joint) procedures listed in the table set forth in the Covered Service Categories section above. These procedures are collectively referred to in this SPD as "Exclusive Lantern Surgery Care Procedures". Exclusive Lantern Surgery Care Procedures will not be covered by your UMR health plan. Accordingly, you will only be able to receive coverage for Exclusive Lantern Surgery Care Procedures by utilizing the Lantern Surgery Care Network.

How Lantern Surgery Care Works

To receive benefits through Lantern Surgery Care relating to a covered medical procedure, you must first contact Lantern Surgery Care and speak with a Care Advocate to schedule a consultation with a Lantern Surgery Care Provider. To get started, you may contact Lantern Surgery Care at (855)-200-2099.

When you call, a Care Advocate will be assigned to your case to assist you with coordinating the medical care that is best for you. The Care Advocate will help you find a qualified Lantern Surgery Care Provider, and will also ensure that you have access to information as you make decisions about your medical care. The Care Advocate will provide guidance throughout the process, answering questions that arise and handling certain logistics throughout the course of your medical journey.

All services under the Lantern Surgery Care benefit must be determined to be a Medically Necessary Service by a Lantern Surgery Care Provider before they are performed. Your Care Advocate will assist with coordinating this for you by scheduling a consultation with a Lantern Surgery Care Provider.

If your Lantern Surgery Care Provider determines that your requested medical procedure is not a Medically Necessary Service, which includes a determination of whether you are a suitable candidate for the procedure, you may request Lantern Surgery Care provide you additional Lantern Surgery Care Provider options to review your case and offer additional opinions and, with the exception of Exclusive Lantern Surgery Care Procedures, you may alternatively seek coverage for the requested medical procedure through your UMR health plan outside of the Lantern Surgery Care benefit.

Lantern Surgery Care will administer claims for services provided during your Episode of Care. Episode of Care means the period of time initiated on the first day you receive covered services through Lantern Surgery Care in an inpatient, outpatient, surgery center, in-office, or other health care facility setting from a Lantern Surgery Care Provider and ends when you are discharged from the applicable health care

facility. All care received from Lantern Surgery Care Providers during an Episode of Care is covered under the Lantern Surgery Care benefit. The services typically covered during an Episode of Care are professional services performed by the Lantern Surgery Care Provider and their staff, inpatient or outpatient facility services, supplies, and equipment, and professional anesthesia services, supplies, or equipment necessary to perform your surgical procedure. For information relating to appeals of any denied Lantern Surgery Care claims, please see the Appeals section below.

Lantern Surgery Care does not cover certain medical consultations and diagnostic testing provided before or after an Episode of Care (for example, services, such as lab work or imaging, provided to determine whether or not your surgical procedure is a Medically Necessary Service), convenience items (for example, charges for telephone use, premium television access, guest meals, or other similar items or services furnished for your convenience/comfort), any medical procedure or medical care that is not Medically Necessary, or medical services or items that are provided by healthcare providers that are not in the Lantern Surgery Care Network. Additionally, Lantern Surgery Care does not cover services which were not coordinated by a Care Advocate. Although the foregoing excluded services would not be covered through Lantern Surgery Care, they might be covered by your UMR health plan.

Note, if you are instructed by Lantern Surgery Care Provider to obtain imaging, such as an MRI, or if a Lantern Surgery Care Provider gives you an order for lab work in advance of your procedure, you should inform your Care Advocate of those instructions. Your Care Advocate will assist you in locating an imaging center or laboratory testing facility that is in-network under your UMR health plan, and the Care Advocate will remind you that those services are not covered through Lantern Surgery Care, so you should present your UMR ID card when obtaining those services.

Copays, Deductibles, and Coinsurance

Services performed by Lantern Surgery Care Providers are not subject to the applicable copay, deductible and coinsurance requirements of your applicable health plan, as detailed below:

Health Plan	Copay	Deductible	Coinsurance	Annual Out of Pocket Maximum
PPO 002 Plan	$0	Yes, to Plan Limit, collection at end-of-year	Waived	Same as Deductible
HDHP 003 Plan	$0	Yes, to Plan Limit collection at end-of-year	Waived	Same as Deductible
PPO 004 Plan	$0	Yes, to Plan Limit collection at end-of-year	Waived	Same as Deductible
PPO 005 Plan	$0	Yes, to Plan Limit collection at end-of-year	Waived	Same as Deductible

As the table above illustrates, your cost share requirements are waived for services received through Lantern Surgery Care. All claims paid by your health plan for services covered through Lantern Surgery Care are considered in-network.

Travel Benefits Through Lantern Surgery Care

Generally, the Lantern Surgery Care Network is broad enough that significant travel is not required. If travel is required, certain travel expenses may be covered through Lantern Surgery Care. A summary of travel benefits available to you through Lantern Surgery Care is set forth below. You should direct questions relating to travel benefits to your Care Advocate.

Description	0 - 99 Miles	100 - 199 Miles	200+ Miles
Travel incentive - Hotel	Hotel expenses not covered	Hotel expenses covered	Hotel expenses covered
Travel incentive - Airfare	Airfare expenses not covered	Airfare expenses not covered	Airfare expenses covered
Travel incentive - Car	$25 mileage reimbursement	$50 mileage reimbursement	$100 mileage reimbursement
Travel incentive - Per Diem	$35 per diem for expenses	$35 per diem for expenses	$35 per diem for expenses
Companion Coverage	Hotel/transportation costs for companion covered	Hotel/transportation costs for companion covered	Hotel/transportation costs for companion covered

Your ID Card

All members of UMR health plans will receive a Lantern Surgery Care ID card following enrollment in the health plan. This ID card includes the Lantern Surgery Care contact information to utilize this benefit if you need non-emergent surgery. If you need replacement or additional cards (for instance, if your child is attending college out of town), you can request them by calling a Care Advocate at (855)-200-2099. It is important to remember to use your Lantern Surgery Care ID card with the Lantern Surgery Care Provider rather than your UMR health plan's insurance card.

Claims and Appeals Procedures

Lantern Surgery Care Claims Procedures

The claims and appeals procedures described in this section do not apply to services performed by health care providers who are not in the Lantern Surgery Care Network. Please review the applicable plan documents for your UMR health plan for the claims and appeals procedures applicable to other benefits available under your plan for more information.

IMA Financial Group has delegated claims and appeals authority for Lantern Surgery Care to Lantern Specialty Care. Lantern Specialty Care, acting on behalf of IMA Financial Group, will provide the following claims and appeals review services set forth in this section relating to Lantern Surgery Care.

Claims Administrator

The Claims Administrator for the Lantern Surgery Care benefit is Lantern Specialty Care and includes all references to the term “Claims Administrator” in this section.

Lantern Specialty Care
Attn: Member Services
2100 Ross Avenue, Suite 1900
Dallas, Texas 75201

Medically Necessary Services

All services under the Lantern Surgery Care benefit must be determined to be Medically Necessary by a Lantern Surgery Care Provider before they are performed. Your Care Advocate will coordinate this for you.

If your Lantern Surgery Care Provider determines that your requested medical procedure is not Medically Necessary, which includes a determination of whether you are a suitable candidate for the procedure, you may request Lantern Surgery Care assign you another Lantern Surgery Care Provider in the Lantern Surgery Care Network to review your case and offer a second opinion. If no Lantern Surgery Care Provider determines your requested medical procedure is Medically Necessary, you may also seek coverage for the requested medical procedure through your UMR health plan (subject to the coverage terms and exclusions of your UMR health plan) except for Exclusive Lantern Surgery Care Procedures. Please review the applicable plan documents for your UMR health plan for more information about your other medical benefits available under your plan.

Please note: A determination by a Lantern Surgery Care Provider that a medical procedure is not Medically Necessary is a determination by the Lantern Surgery Care Provider that he or she will not perform the requested medical procedure and is not a denial of your benefits by and under your plan. In that situation, the appeals procedures described in the following section will not apply. The appeal procedures described in the following section apply only if and when your requested medical procedure is wholly or partially denied by the Claims Administrator acting on behalf of your plan.

Claims Submission

To receive coverage through Lantern Surgery Care, you must use a Lantern Surgery Care Provider. All claims for benefits received from a Lantern Surgery Care Provider for covered services will be paid by the Claims Administrator on behalf of IMA Financial Group. Generally, no claims for payment must be filed by you. Rather, Lantern Surgery Care Providers will submit your claims directly to the Claims Administrator for services provided to you or any of your covered dependents.

Please contact your Care Advocate or the Claims Administrator with any questions regarding filing a claim for benefits under Lantern Surgery Care. Additional information about your Lantern Surgery Care benefit is available on your member portal. Your member portal can be accessed at: www.myimabenefits.com

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Claims Administrator in the proper manner and form and with all of the information required. In the event a claim is not complete, the Claims Administrator will notify you and/or your Lantern Surgery Care Provider, and the Claims Administrator will work with you and/or the Lantern Surgery Care Provider to complete the claim and resubmit it to the Claims Administrator. The Claims Administrator will work to ensure completed claim forms are timely filed on your behalf by Lantern Surgery Care Providers.

If approved, you will receive an explanation of benefits summary from the Claims Administrator after your medical procedure is performed. If denied, you will receive an adverse benefits determination (please see Claim Denial Notification section below).

Who Receives Payment

Benefit payments will be made directly to Lantern Surgery Care Providers when they bill the Claims Administrator. Except as provided elsewhere in this SPD, rights and benefits under your plan are not assignable, either before or after services and supplies are provided. Any benefits that are or may be payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Claim Denial Notification

In the event a claim for benefits through Lantern Surgery Care is wholly or partially denied, the Claims Administrator shall provide you with written notification of the adverse benefit determination. The notification shall be written in a manner calculated to be understood by you and shall include the following:

1. Information necessary to identify the claim, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability upon request, of the diagnosis code and its meaning and the treatment code and its meaning;

2. The specific reason or reasons for the adverse determination including the denial code and its corresponding meaning as well as a description of your plan's standard, if any, that used in denying the claim;

3. Reference to the specific provision of your plan on which the determination is based;

4. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

5. Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

6. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

7. A description of your plan's available internal appeals and external review processes, including information regarding how to initiate an appeal, and the time limits applicable to such procedures; and

8. A statement of your rights to bring a civil action under ERISA Section 502(a) following a final adverse benefit determination after appeal and contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures.

If your claim has been denied and you do not agree with the denial, you must submit your claim for review by following the Lantern Surgery Care Appeals Procedure described below.

Lantern Surgery Care Appeals Procedures

If you disagree with a denial of your claim, you or your duly authorized representative acting on your behalf must file an appeal in writing. All references to you for the remainder of this Appeals Procedure section also include your duly authorized representative, if any. These appeal procedures must be exhausted before you can enforce your rights under ERISA.

Appeals Administrator

The Appeals Administrator for the Lantern Surgery Care benefit is MCMC, LLC and includes all references to the term "Appeals Administrator" in this section.

MCMC LLC
300 Crown Colony Drive, Suite 203
Quincy, MA 02169
www.mcmcllc.com

Filing an Appeal

You have 180 days from the time that you receive a claim denial from the Claims Administrator to file an appeal. There are two levels of appeal for pre- service claims for benefits under your plan's Lantern Surgery Care benefit:

- Level 1 appeal: You may file a level 1 appeal with the Claims Administrator within 180 days if your claim for benefits is denied and you would like to appeal that denial. Your appeal will be reviewed by the Appeals Administrator within 15 days, with no extensions.
- Level 2 appeal: If your first appeal is denied by the Appeals Administrator, you may file a level 2 appeal with the Claims Administrator within 60 days, and your appeal must be considered by the Appeals Administrator within an additional 15 days, with no extensions.

Appeals (both Level 1 and Level 2) must be filed with the Claims Administrator. The Claims Administrator will notify the Appeals Administrator of your appeal and forward your request for appeal and any information you provide described below under your rights when filing an appeal. The review periods described above begin when you file your appeal with the Claims Administrator.

You have the following rights when filing an appeal (applicable to both Level 1 and Level 2 appeals):

- You may submit written comments, documents, records and other information relating to the claim for benefits in connection with your appeal, and the review of your appeal will take into account all such comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- You may submit additional evidence and testimony in support of your appeal.
- If any new evidence is provided by your plan or any new rationale is considered by the Appeals Administrator in making the decision, you must receive notice of such new evidence and new rationale and have an opportunity to respond. You must respond within the time period during which the Appeals Administrator is considering your appeal.
- You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- The Appeals Administrator will not afford deference to the initial adverse benefit determination (and to the Level 1 adverse benefit determination for a Level 2 appeal), and the review will be conducted by an appropriate individual who is neither the individual who made the adverse benefit determination nor the subordinate of such individual.

- In deciding a claim for review that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental/investigational or not Medically Necessary or appropriate, the Appeals Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. Any such health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of review, nor the subordinate of any such individual.
- The Appeals Administrator will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of your plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Appeal Denial Notification

In the event a claim for benefits is wholly or partially denied on appeal, the Appeals Administrator shall provide you with written or electronic notification of the adverse benefit determination. The notification shall be written in a manner calculated to be understood by you and shall include the following:

1. Information necessary to identify the claim, including the date of service, healthcare provider, claim amount (if applicable), and a statement describing the availability upon request, of the diagnosis code and its meaning and the treatment code and its meaning;
2. The specific reason or reasons for the adverse determination including the denial code and its corresponding meaning as well as a description of your plan's standard, if any, that used in denying the claim;
3. Reference to the specific provision of your plan on which the determination is based;
4. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of your plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;
5. Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;
6. A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
7. A description of any voluntary appeal procedure available under your plan, including information regarding how to initiate an appeal, and the time limits applicable to a voluntary appeal; and
8. A description of your plan's available external review procedure, including information regarding how to initiate an appeal, and the time limits applicable to external review;
9. A statement of your right to bring a civil action under ERISA Section 502(a) following a final adverse benefit determination on appeal (i.e. Level 2), and contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures; and
10. A statement that reads as follows: "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."

External Review Procedures

Request for Standard External Review

If you disagree with the final adverse benefit determination of your claim on appeal, you may request an external review. External review under the Lantern Surgery Care benefit is available for an adverse benefit determination that involves medical judgment (including, but not limited to, those based on whether a benefit is Medically Necessary, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational), as determined by the external reviewer.

You may only file a request for external review if you file such request within four months of the date you received your plan's final adverse benefit determination on your claim for review from the Appeals Administrator.

Your request for an external appeal must be filed with the Claims Administrator. The Claims Administrator will notify the Appeals Administrator of your request for external review and forward your request for appeal and any information you provide described below under your rights when filing an appeal.

Review and Preliminary Determination of Eligibility for External Review

The Appeals Administrator must review your request and respond to you within five business days of receipt of your request with a determination of whether your claim is eligible for external review. The review period begins when you file your request for external review with the Claims Administrator. A claim is eligible for external review if it meets all of the following four requirements during the preliminary review.

1. You are or were covered by your plan at the time the health care item or service in question was provided;

2. Your claim is not based upon whether you satisfied your plan’s eligibility requirements;

3. You have exhausted your plan’s internal appeal process, unless you were not required to do so because of an error during the claims and appeals process by the Claims Administrator or Appeals Administrator that excuses you from completing the internal appeal process; and

4. You provided all the information and forms required to process an external review.

Preliminary Notice Regarding Eligibility

Within one business day after the Appeals Administrator completes the preliminary review, your plan must issue a written notice to you stating the reasons the claim is not eligible for external review if the request was complete but not eligible for external review and must also provide contact information for the Employee Benefit Security Administration (toll-free number 866-444-EBSA (3272)). If your request for external review was not eligible because it was incomplete, the notice must include a description of the information necessary for you to complete the request for external review and permit you to submit such information by the later of 48 hours after you receive the notice or by the end of the four month period during which external review must be requested.

External Review

Your plan must rotate its assignment of claims for external review to an independent review organization that is one of the at least three independent review organizations retained by your plan to conduct external reviews and which is due to receive the claim on your plan’s rotational basis established to ensure independence. The external independent review organization must conduct a full review of the file, applicable plan provisions and any material submitted as required by applicable guidance and in compliance with the independent review organization’s contract with your plan. The independent review organization shall conduct such review on a de novo basis without deference to the plan’s decision.

Within four business days after the independent review organization is assigned, the Appeals Administrator, acting on behalf of your plan, shall provide the documents and information considered by your plan in making its decision. If the independent review organization receives any new evidence or information, it shall provide such information to the Appeals Administrator and the Appeals Administrator

may reconsider its decision. If the Appeals Administrator changes its decision upon reconsideration, it must notify the claimant and the independent review organization of its new decision within one business day of making such decision. The independent review organization must then terminate its review.

The independent review organization shall provide the claimant and Appeals Administrator with a written notice of its decision within 45 days of the date on which the independent review organization received the request for external review. Such notice shall include all information required by applicable guidance.

Upon the Appeals Administrator's receipt of an independent review organization's final external review determination reversing the Appeals Administrator's determination, the Appeals Administrator shall promptly notify your plan, and your plan shall immediately provide coverage or payment for the claim.