



Lantern Surgery – Benefit Booklet

Preface

This booklet explains how the Lantern Surgery Care benefit works. Lantern Surgery Care is a supplemental surgical benefit administered by Lantern Specialty Care and is available to members enrolled in a Canon Medical System USA (CMSU) health plan. The medical benefits described in this booklet are provided and paid for by the CMSU health plan; they are not insured by Lantern Specialty Care. Lantern Specialty Care supports the program by providing administrative and care coordination services. Coverage under the Lantern Surgery Care benefit is effective January 1, 2026.

This booklet outlines your rights and responsibilities, the services that are covered, and how benefits are paid. You are responsible for understanding the terms of this coverage. This booklet replaces all previous materials describing Lantern Surgery Care benefits that you may have received.

We encourage you to read this booklet 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 Lantern Surgery Care administrator, Lantern Specialty Care, at 855-210-3686, or reach out to CMSU's Benefits Department at Benefits@us.medical.canon.

Separate summaries describing other benefits available under the CMSU health plan are also available and may be obtained by contacting CMSU's Benefits Department at Benefits@us.medical.canon.



Participation in Lantern Surgery Care Benefits

Who Is Eligible for Lantern Surgery Care

If you are eligible for coverage under a CMSU health plan, you are also eligible for coverage through Lantern Surgery Care. For information about eligibility requirements under the CMSU health plan, please contact CMSU's Benefits Department at Benefits@us.medical.canon.

Enrollment in Lantern Surgery Care

Lantern Surgery Care is automatically included with enrollment in a CMSU health plan. You do not need to make a separate election to receive this benefit, and coverage cannot be elected on a standalone basis. For details about enrolling in a CMSU health plan—including how to enroll, when coverage begins, and how to make changes during the year—please contact CMSU's Benefits Department at Benefits@us.medical.canon.

When Lantern Surgery Care Coverage Ends

In general, coverage under Lantern Surgery Care ends when your CMSU health plan coverage ends. For information about when coverage ends and options for continuing coverage (including COBRA or other continuation rights), please contact CMSU's Benefits Department at Benefits@us.medical.canon.



Lantern Surgery Care Benefits

Overview

The Lantern Surgery Care benefit is a comprehensive surgical program that provides access to covered services through a high-quality network of credentialed surgeons and facilities. You will also receive personalized support from a dedicated team of Care Advocates who offer a concierge-style experience throughout your surgical journey.

The goal of Lantern Surgery Care is to simplify the surgical process from start to finish—from helping you choose a qualified surgeon to coordinating appointments and assisting with certain medical bills related to your care. All Lantern Surgery Care surgeons undergo a rigorous credentialing process to ensure you receive high-quality care from specialists with expertise in the procedures they perform. By using the Lantern Surgery Care benefit, you may also benefit from reduced member cost-sharing.

Covered Service Categories

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

Orthopedic (Joint) Most common procedures: <ul style="list-style-type: none"> • Replacement: Knee, Hip, Shoulder, Ankle, Elbow, and Wrist • Revision: Knee, Hip, Shoulder, Ankle, Elbow, and Wrist 	Orthopedic Most common procedures: <ul style="list-style-type: none"> • Joint Arthroscopy • Ligament Repair • Rotator Cuff Repair • Bunionectomy • Carpal Tunnel Release 	Cardiac Most common procedures: <ul style="list-style-type: none"> • Defibrillator Implant • Pacemaker Implant • Pacemaker Replacement • Valve Surgery • Cardiac Ablation 	Bariatric Most common procedures: <ul style="list-style-type: none"> • Gastric Bypass • Sleeve Gastrectomy • Lap Band • Lap Sleeve 	Gastroenterology (GI) Most common procedures: <ul style="list-style-type: none"> • Colonoscopy • Endoscopy
Spine Most common procedures: <ul style="list-style-type: none"> • Laminectomy • Laminotomy • Lumbar Interbody Fusion • Cervical Disk Fusion • 360 Spinal Fusion • Artificial Disk Replacement 	Genitourinary (GYN) Most common procedures: <ul style="list-style-type: none"> • Hysterectomy • Hysteroscopy • Myomectomy • Bladder Repair • Ovary Removal 	General Most common procedures: <ul style="list-style-type: none"> • Hernia Repair (inguinal, ventral, umbilical, or hiatal) • Laparoscopic Cholecystectomy • Thyroidectomy • Excision of Mass/ Biopsy 	Ear, Nose, and Throat Most common procedures: <ul style="list-style-type: none"> • Ear Tube Insertion • Ear Infection • Septoplasty • Sinuplasty 	Pain Management Most common procedures: <ul style="list-style-type: none"> • Cervical Epidural • Lumbar Epidural Steroid • Stellate Ganglion Block • Epidural Blood Patch

Lantern Surgery Care Provider Network

Providers affiliated with Lantern Surgery Care agree to provide health care services and supplies at negotiated rates and are referred to in this booklet as **Lantern Surgery Care**



Providers. Lantern Surgery Care Providers include physicians, other licensed health care practitioners, hospitals, and health care facilities. Collectively, these providers are referred to as the **Lantern Surgery Care Network**. The Lantern Surgery Care Network is separate from the provider network associated with your CMSU health plan, although some Lantern Surgery Care Providers may also participate in the CMSU health plan's provider network.

Optional Benefits Through Lantern Surgery Care

Participation in Lantern Surgery Care is voluntary. You may choose to receive covered services from licensed providers, hospitals, or facilities outside of the Lantern Surgery Care Network. However, services received from providers outside of the Lantern Surgery Care Network are not covered under the Lantern Surgery Care benefit.

Services provided by non-Lantern Surgery Care providers may be covered under your CMSU health plan, subject to applicable deductibles, coinsurance, and other plan terms. In those cases, you will not be eligible for the reduced cost-sharing available through Lantern Surgery Care, such as waived deductibles, or coinsurance. If you choose not to use Lantern Surgery Care for a surgical procedure, please refer to your CMSU health plan documents for information about coverage and cost-sharing.

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 855-210-3686.

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 CSMU 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 CSMU 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 CSMU health plan, and the Care Advocate will remind you that those services are not covered through Lantern Surgery Care, so you should present your CSMU health plan ID card when obtaining those services.

Copays, Deductibles, and Coinsurance

When you use Lantern Surgery Care, you may pay less—or nothing at all—depending on your CSMU health plan. Details about your costs under each health plan are shown below.

Health Plan	Deductible	Coinsurance	Out of Pocket Maximum Individual / Family
Aetna Basic – HRA HDHP	\$0 (Waived)	0% (Waived)	\$6,000 / \$12,000
Aetna Basic – HSA HDHP	Collect (IRS Minimum)	0% (Waived)	\$6,000 / \$12,000
Aetna Select – HRA HDHP	\$0 (Waived)	0% (Waived)	\$5,000 / \$8,500



Aetna Select – HSA HDHP	Collect (IRS Minimum)	0% (Waived)	\$5,000 / \$8,500
Aetna Premier – EPO	\$0 (Waived)	0% (Waived)	\$6,000 / \$12,000
Aetna Premier – HRA HDHP	\$0 (Waived)	0% (Waived)	\$3,000 / \$6,000
Aetna Premier – HSA HDHP	Collect (IRS Minimum)	0% (Waived)	\$3,000 / \$6,000

As the table above illustrates, your cost share requirements may be 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 necessary, certain travel-related expenses may be covered through Lantern Surgery Care. A summary of the travel benefits available to you is provided below. If you have questions about travel benefits, please contact your Care Advocate.

Travel Incentives			
Description	0 - 99 Miles	100 - 199 Miles	200+ Miles
Hotel	Hotel expenses not covered	Hotel expenses covered	Hotel expenses covered
Airfare	Airfare expenses not covered	Airfare expenses not covered	Airfare expenses covered
Car	\$25 mileage reimbursement	\$50 mileage reimbursement	\$100 mileage reimbursement
Per Diem	\$35 per diem for expenses	\$35 per diem for expenses	\$35 per diem for expenses
Companion Coverage	Companion is eligible for same travel as member		

Your ID Card

All members enrolled in a CMSU health plan will receive a Lantern Surgery Care ID card after enrolling in the health plan. This ID card includes Lantern Surgery Care contact information to help you access this benefit if you need non-emergent surgery. If you need a replacement card or additional cards (for example, if a dependent is attending college away from home), you may request them by calling a Care Advocate at **855-210-3686**. When receiving services from a Lantern Surgery Care Provider, be sure to present your Lantern Surgery Care ID card rather than your CMSU health plan 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 CSMU health plan for the claims and appeals procedures applicable to other benefits available under your plan for more information.

CSMU has delegated claims and appeals authority for Lantern Surgery Care to Lantern Specialty Care. Lantern Specialty Care, acting on behalf of CSMU, 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 CSMU health plan (subject to the coverage terms and exclusions of your CSMU health plan) except for Exclusive Lantern Surgery Care Procedures. Please review the applicable plan documents for your CSMU 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 covered services received from a Lantern Surgery Care Provider will be paid by the Claims Administrator on behalf of CMSU. In most cases, you do not need to file any claims yourself. Instead, Lantern Surgery Care Providers will submit claims directly to the Claims Administrator for services provided to you or your covered dependents.

Please contact your Care Advocate or the Claims Administrator if you have any questions about filing a claim for benefits under Lantern Surgery Care. Additional information about your Lantern Surgery Care benefits is available through your member portal, which can be accessed at **my.lanternicare.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 document, 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.mcmllc.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.