

## NOTICE OF APPEAL RIGHTS (Updated 8/1/2011)

You should contact the NHAH Compliance Office at (800) 645-1195 when you:

- ◆ Do not understand the reason for the denial;
- ◆ Do not understand why the health care service or treatment was not fully covered;
- ◆ Do not understand why a request for coverage of a health care service or treatment was denied;
- ◆ Cannot find the applicable provision in your Benefit Plan Document;
- ◆ Want a copy (free of charge) of the guidelines, criteria or clinical rationale that we used to make our decision; or
- ◆ Disagree with the denial or the amount not covered and you want to appeal;
- ◆ If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim; and
- ◆ If your request for service has been denied as not being “medically necessary” as defined by the Plan or as “experimental” or “investigational”.

All appeals for claim denials (*or any decision that does not cover expenses you believe should have been covered*) must be sent in writing to the NHAH Compliance Office at 416 Creekstone Ridge, Woodstock, GA 30188 within **180 days** of the date you receive our denial. Denials or reduced payment of benefits will be as noted on your **Explanation of Benefits (EOB)**. **The member will receive an Explanation of Benefits for every claim paid by the plan.**

A copy of the Explanation of Benefits (EOB) is provided to your provider when there is an assignment of benefits on the claim and to the primary member. Please be sure to review your EOB, especially the footnotes and remark code that indicate how a claim was paid, any claim adjustment, or the information needed in order to reprocess the claim for payment.

The NHAH Compliance Office will provide a full and fair review of your claim upon appeal. If you wish your appeal to be handled by an authorized representative, this authorization must be submitted in writing. You may also submit a general HIPAA Authorization which would permit the authorized party to act on your behalf of obtain information on your claims, benefits, etc. on an ongoing basis. Any Medical Power of Attorney should be submitted to the plan.

The member, authorized representative or the provider must submit all appeals in writing along with any additional documentation to protect their rights under the Plan. You should provide the NHAH Compliance Office with any additional information that relates to your claim. You may request copies of information that we have that pertains to your claims.

The individuals in the compliance office are associated with NHAH, but they are not involved in the claims payment process or the initial denial of your claim. The Compliance Dept. operates independently of the Claims Dept. and Precertification Dept. It is their function to fairly and impartially review any appeal to determine if it was properly paid or denied and to advise you of its ultimate findings. They will also advise you of the specific language in the plan that supports the denial or claims payment as appropriate based each individual situation. When appropriate, the Compliance Dept. may rely on information provided by the Precertification Dept. or other Departments in reaching a final decision.

External review for adverse benefit determinations and final internal adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefits or care is available as of July 1, 2011. Under NHAH's External Review Process, your appeal will be submitted to an Independent Review Organization (IRO), one of three retained by the Plan on a rotating basis. **The decision of the IRO is binding under the Plan on both the Plan and the Member. A \$25 filing fee is required for any request for External Review.**

The NHAH External Review Request Form will be made available online at [www.nhai.net](http://www.nhai.net). A copy of these policies and a complete Summary Plan Description of your Medical and Dental Plan is also available online. You must enter the Plan # as found on your ID card to access the Plan documents.

Appeal information is required to be provided in another language if required if 10% of the population in the county where the claimant resides speaks the same non-English language. based on the percentage of the population which speaks a foreign language as if the primary coverage area of the plan is

We will notify you of our decision in writing within **30 days (60 days for a complex claim)** of receipt of your written appeal. If you do not receive our decision within **60 days** of receipt of your appeal, you may be entitled to file a request for external review.

Your appeal rights under the NHAI Plan have been updated to conform to Section 2719 of the Public Health Service (PHS) Act, as added by the Affordable Care Act of 2010 (Health Care Reform Act). Your review and appeal rights explained below and include the following 16 minimum consumer protection standards as summarized in Technical Release 2011-02:

1. The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
2. Issuers (or plans) must be required to provide effective written notice to claimants of their rights to external review.
3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis (minimal) violations that do not cause, and are not likely to cause, prejudice or harm to the claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.
4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer (or plan), although the process may require a nominal filing fee (*not to exceed \$25 per appeal up to \$75 during any calendar year*) from the claimant requesting external review.
5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (*such as rotational assignment*), and in no event assigned by the issuer, the plan, or the individual.
8. The process must provide for the maintenance of a list of approved IROs (*only those that are accredited by a nationally recognized private accrediting organization*) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.
9. Approved IROs must have no conflicts of interest that will influence their independence.
10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer (or plan) within one business day of receipt by the IRO.
11. The IRO decision must be binding on the claimant, as well as the plan or issuer (*except to the extent other remedies are available under State or Federal law*). The requirement that the decision be binding does not preclude a plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision.
12. For standard external review, the IRO must provide written notice to the Plan and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review.
13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the

request for external review (*and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision*).

14. Plans must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.
15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.
16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.

## APPEAL CHART

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| <b>Who May File an Appeal</b>                                       | Any covered member or a Primary Member on behalf of a covered dependent; or any authorized representative, including a provider on behalf of the patient. All appeals must be filed with the NHAI Compliance Office except for Urgent Care Appeals which must be filed with the NHAI Precertification Dept.   |
| <b>Pre-service Claim</b>  | Request must be made <b>within 60 days of a previous denial</b> . <i>A response must be provided within 24 hours for an Urgent Care Claim (excluding weekends and holidays) and 30 days for all other pre-service claims.</i>   |
| <b>Post Service Claim</b>   | All appeals must be filed within 180 days of the initial denial. All post service claims will be responded to within 30 days unless additional time is required. A response will be made in nor more than 60 days of the date of the appeal.  |
| <b>Informal Appeal (optional)</b>                                   | Informal review of any claim based on the Explanation of Benefits (EOB). Any request for review must be made within 180 days of the initial denial. It is recommended that all Appeals be submitted in writing. Verbal requests <u>are not</u> considered to be a “formal” appeal, but will be given every possible consideration on and fair and impartial basis to resolve the issue.   |
| <b>Level 1 – Formal Written Appeal</b>                              | This must be filed <b>in writing</b> within 180 days of the initial denial based on the n Explanation of Benefits (EOB) date. All details with respect to disputed charges and any extenuating circumstances must be provided either by the Member or the Provider (or both).   |
| <b>Level 2 – Second Written Appeal on a Previously Denied Claim</b> | A second appeal must be filed within 45 days of the previous denial. Once a final Adverse Determination is made, the Internal Appeals Process is deemed exhausted. Members must submit all relevant information and any additional information with each appeal in writing in order to comply with the Internal Appeal Rules. Each appeal will be reviewed as if it were a new appeal, with “fresh eyes” or on a “de novo” (new) basis.   |
| <b>Internal Appeal Process</b>                                      | Initial appeals are handled by the Assistance Compliance Officer. Any appeal of a decision by the Assistant Compliance Officer will be reviewed and a final determination will be made by the Compliance Officer. The decision of the Compliance Officer will be the Final Internal Appeal determination.   |
| <b>Peer Review Process</b>  | <p>The Plan reserves the right, as part of its internal review process to forward any prospective or retrospective claim, request for treatment, or continued treatment when there is a question of “<i>medical necessity</i>”, “<i>appropriateness of treatment</i>” or “level of care” or “<i>effectiveness of care</i>” is an issue to an <b>Independent Review Organization (IRO)</b> for a <b>Peer Review</b>.</p> <p>The Independent Review Organization (IRO) will be totally independent of NHAI and the Plan and its findings shall be binding on the Plan. The IRO utilized will be staffed by appropriate professionals who are Board Certified in the particular area of medicine involved and a copy of the review notes will be provided to the member and the provider as part of the review process. Whenever an independent Review has been conducted, the internal claims review process shall be considered to have been exhausted regardless of who requested the initial review. IRO shall be selected by NHAI on a random basis among those IRO available for the presenting condition. <b>The member, provider, or authorized representative is permitted to request a Peer Review within 60 days following an adverse benefit decision by the Plan of either a pre-service or post service claim.</b></p> |

## EXTERNAL APPEALS

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| <p><b>External Review by Independent Review Organization (IRO)</b></p>    | <p>Following final Level 2 denial or may be requested simultaneously when filing an appeal may be requested or provided by the plan in the event of a dispute based on medical necessity, appropriateness of care, health care setting, level of care or effectiveness of a covered benefit or care. The External Review will be conducted by an Independent Review Organization (IRO) selected by the Plan on a rotating basis to insure an impartial and fair decision that will be binding on the plan. An external review must be requested within 4 months of the initial denial. <b>NHAI Plans have elected to engage in private accredited IRO's to handle external appeals.</b></p> <p>(1) Generally, a request for an external review may not be made until the internal review process has been exhausted. If our decision involved making a judgment as to the <u>medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment</u>, you may submit a request for external review within <b>4 months</b> after receipt of the initial denial. <u>An external review may be requested with your initial appeal.</u></p> <p>(2) Appeals involving medical judgment (<i>excluding those that involve only contractual or legal interpretation without any use of medical judgment</i>) as determined by the review; or Rescission of coverage. (<i>Termination due to failure to pay premiums or due to loss of eligibility per plan rules does not constitute a rescission of coverage</i>).</p> <p>For a standard external review, a decision will be made within <b>30 days (45 if additional time is needed or if additional documentation or date is required)</b> of receipt of your request.</p> |
| <p><b>Expedited External Review:</b></p>                                  | <p>If you have a medical, behavioral, or addictive condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an <b>expedited external review</b> of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational or not medically necessary, you may also be entitled to file a request for external review of our denial.</p> <p>If a treatment program is in progress and the plan denies further treatment <u>without an IRO review</u>, then treatment will continue to be covered until the IRO completes its review and the provider and member are advised of the IRO findings. Both the Plan and the Member are required to abide by the decision and findings of the IRO under the Appeal Rules under the Affordable Health Care Act (ACA). If the external review findings are in favor of the claimant, benefits will be covered retrospectively during the review period.</p>  |
| <p><b>Coverage during the Review Process</b></p>                          | <p>If initial denial of benefits or continued treatment is based on findings of an Independent Review Organization (IRO) benefits <u>will not</u> be covered during the second appeal process if the provider or member disagrees with the initial decision. If the second IRO opinion is different from the initial IRO a third review will be requested.</p>  |
| <p><b>Appeal of an IRO Decision under the External Claims Process</b></p> | <p>The member or provider is permitted to appeal an IRO decision <u>once</u>, provided a second review is requested within <b>30 days</b> of the initial review and there is additional information being submitted for review. The second review must be conducted by a different Board Certified Professional who may be from the same IRO as the first reviewer. The findings of an IRO shall constitute a final decision unless the second review differs from the initial IRO finding. In this situation, a third review shall automatically be requested by the Plan from a separate IRO. The</p>   |

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|   | findings of an IRO shall be considered binding on all parties, except to the extent that another remedy is available under Federal law. <b>Your review or appeal rights, both internally and externally, will be deemed exhausted once the IRO process is finalized.</b> The fees for all IRO reviews shall be paid by the Plan.   |
| <b>All Other Appeals</b><br><i>(not eligible for External Appeals)</i>  | <b>Includes appeals not related to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefits or care, such as --</b> appeals involving eligibility for benefits; non payment of a claim; late filing penalties; failure to precertify benefits in advance of treatment as required by the plan; penalties for failure to complete a treatment program; payment as out of network instead of in network or out of area; payment under coordination of benefit rules or where primary plan's EOB was not submitted with claim, etc. |
| <ul style="list-style-type: none"> <li>• Claims not received or paid by the plan where no Explanation of Benefits (EOB) or Claim Denial was issued</li> </ul> | <u>Claims must be filed within 1 year from the date of service.</u> Claims not received within one year will not be considered for payment absent extenuating circumstances. All requests for consideration must be submitted in writing to the NHAI Compliance Office by the member or provider with all relevant facts and mitigating circumstances within 18 months from the date of service. Late filing penalties apply to these claims, even if approved for payment by the Plan.  |
| <ul style="list-style-type: none"> <li>• Claims where an Explanation of Benefits (EOB) was issued</li> </ul>  | Any claim disputing how a particular claim or benefit was paid must be filed within 180 days (6 months) from the Explanation of Benefits (EOB) date. <b>Claims filed after 180 days will not be considered for payment absent extenuating circumstances acceptable at the sole discretion of the plan.</b>   |

**Examples of situations where an external review may be requested:**

1. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
2. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the plan's standard for medical necessity or appropriateness);
3. Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
4. A determination that a medical condition is a preexisting condition;
5. A plan's general exclusion of an item or service (such as speech therapy), if the plan covers the item or service in certain circumstances based on a medical condition (such as, to aid in the restoration of speech loss or impairment of speech resulting from a medical condition);
6. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the plan's wellness program;
7. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
8. Whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

## Definitions for Purposes of the Appeal Rules

For purposes of this Act:

- A. “Adverse determination” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.
- B. “Adverse determination” means a determination by the Plan or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.
- C. “Authorized representative” means:
  - (1) A person to whom a covered person has given express written consent to represent the covered person in an external review;
  - (2) A person authorized by law to provide substituted consent for a covered person; or
  - (3) A family member of the covered person or the covered person’s treating health care professional only when the covered person is unable to provide consent.
- D. “Best evidence” means evidence based on:
  - (1) Randomized clinical trials;
  - (2) If randomized clinical trials are not available, cohort studies or case-control studies;
  - (3) If paragraphs (1) and (2) are not available, case-series; or
  - (4) If paragraphs (1), (2) and (3) are not available, expert opinion.
- E. “Case-control study” means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.
- F. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- G. “Case-series” means an evaluation of a series of patients with a particular outcome, without the use of a control group.
- H. “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- I. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.
- J. “Cohort study” means a prospective evaluation of two (2) groups of patients with only one group of patients receiving a specific intervention(s).
- K. “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.
- L. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled to under the terms of the Plan.