NETCARE
APPEAL AND GRIEVANCE PROCEDURES

The Affordable Care Act ensures your right to an internal appeal or asks NetCare to reconsider its decision to deny payment for a service or treatment. The law also permits you to have an independent review organization (an external review) decide whether to uphold or overturn NetCare's internal appeal decision. NetCare uses guidelines from the Uniform Health Carrier External Review Act to assure you have the opportunity for an independent review of an adverse determination or final adverse determination.

If a claim is denied, in whole or in part, NetCare will furnish notice to you specifying reason or describe any additional information required in perfecting the claim and your right to file an internal appeal. If you wish to review and discuss the reason for the denial, a request must be made in writing to NetCare within **one-hundred eighty (180) days** of receipt of a denial notice. NetCare will re-evaluate the claim in question and give a final written decision on the re-evaluation within sixty (60) days for services already incurred, thirty (30) days for non-urgent care not yet received, or seventy-two (72) hours for urgent care, after such request is received.

NOTICE OF APPEAL RIGHTS

You have the right to appeal any decision we make that denies payment on you claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact our office at 671-472-3610 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 Policy Specification;
- Want a copy (free of charge) of the guideline, 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.

Appeals

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 our office at 424 W. O'Brien Drive, Julale Center Ste 200, Hagatna, Gu 96910 within 180 days of the date you receive our denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that

relates to your claim and you may request copies of information that we have pertaining to your claim. We will notify you of our decision in writing within **60 days** of receiving your appeal. If you do not receive our decision within **60 days** of receiving your appeal, you may be entitled to file a request for an external review.

When you appeal, NetCare must give you its decision within:

1. Urgent Care Claims – 72 Hours Reply Time
A special kind of pre-service claim that requires a quick decision due to a health condition that may be threatened. If your appeal concerns urgent care, you may be able to have the internal appeal and external review take place at the same time.

2. Pre-Service Claims – 30 Days Reply Time
Denials of non-urgent care you have not yet received.

3. Post-Service Claims – 60 Days Reply Time
Claims for benefits under NetCare, including claims after medical care have been provided, such as reimbursement or payment of the costs of the services provided.

External Review

If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **four** (**4) months** after the date you receive our denial to Guam Department of Revenue and Taxation, Office of the Insurance Commissioner, 1240 Army Drive Barrigada, GU 96921, telephone 671-635-1844. For standard external review, a decision will be made within **forty-five (45) days** of receiving your request. If you have a medical 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 expedited external review 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 investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document or contact our office at 671-472-3610, 424 W. O'Brien Drive, Julale Center Ste 200, Hagatna, GU 96910.

Expedited External Review - An expedited process if you have a medical condition where the timeframe for completion of a standard external review, pursuant to the Uniform Health Carrier External Review Act, would seriously jeopardize your life or health or ability to regain maximum function. A decision will be made expeditiously as your medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of your request.