## Important Information about Your Appeal Rights

If you think a claim was denied in error, you have the right to appeal this decision, as stated below. Also, specific details regarding your appeal rights, timelines for filing an appeal and procedures that you need to follow are in the Plan Document/Summary Plan Description for your group health plan. Please review and follow that information very carefully. If you cannot locate the current Plan Document/Summary Plan Description for the benefit plan that you are covered under, please contact Network Health's customer service or check with the employer that sponsors your self-insured group health plan.

**What if I need help understanding this denial?** Contact Network Health's customer service at the phone number listed on the back of your participant ID card. Network Health is the third party administrator for the self-insured group health plan that you are enrolled in.

**What if I don't agree with this decision?** You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

**How do I file an Internal Appeal for services I already received and can I provide additional information about my claim?** Send your written appeal to: Network Health, Commercial Appeal Team, P.O. Box 120, Menasha, WI 54952. Your written appeal should include a copy of the Adverse Benefit Determination (denial) that you are appealing and you may supply additional information to explain why you believe the claim should have been approved.

**What if my situation is urgent and prior authorization is required from the plan before I can receive the service?** If the plan has denied your prior authorization request to have certain services and your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited internal appeal and a simultaneous external review by Network Health's customer service at the phone number listed on the back of your participant ID card or by submitting a written explanation of your appeal as explained in the above provision for Internal Appeals.

**Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an appeal. Please call Network Health's customer service department at the phone number listed on the back of your participant ID card to obtain an authorized representative designation form.

**Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you as well. You can request copies of this information by contacting Network Health's customer service at the phone number listed on the back of your participant ID card.

**What happens next?** If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party who will review the denial and issue a final decision.

**Other resources to help you:** In addition to reviewing appeal rights information in your Summary Plan Description, or calling Network Health's customer service for assistance, you could also contact the Employee Benefits Security Administration at 1-866-444-3272 who may be able to help.

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