**210 NAC Ch. 87 Appendix A**

**Notice of appeal rights**

## NOTICE OF APPEAL RIGHTS

**You have a right to appeal any decision we make that denies payment on your 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[1] us 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 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.[1]

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [health carrier to insert address of where appeals should be sent to the health carrier] within 180 days of the date you receive our denial.[2] 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 that pertains to your claims. We will notify you of our decision in writing within 30 days of receiving your appeal.[3] If you do not receive our decision within 30 days of receiving your appeal, you may be entitled to file a request for external review.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. Once you have completed the internal grievance or appeals process as set forth above, you may be entitled to a standard external review of your claim denial if our decision involved making a judgment as to the medical necessity, experimental or investigational nature, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. You may submit a request for external review within 4 months after receipt of this notice to the Nebraska Department of Insurance at Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089. You may telephone the Department of Insurance for more information at (877) 564-7323. The form required to request an external appeal will be provided with a final adverse benefit determination. In addition, the forms may be accessed on our website or on the Department of Insurance Website at www.doi.nebraska.gov [doi.nebraska.gov]. For standard external reviews, a decision will be made within 45 days of receiving your request. You may be entitled to an expedited external review of an adverse determination. 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, and 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, you may be entitled to file a request for expedited external review of our denial, upon certification by your treating physician. You may not have to complete the internal appeals process to request an expedited external review. The expedited external review may be requested once the internal appeal has been submitted. For details, please review your Benefit Plan Document, contact us or contact the Nebraska Department of Insurance.

1 See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.
2 Unless your plan or any applicable state law allows you additional time.
3 Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's internal appeal process.