ISLAND HOME INSURANCE COMPANY
STAYWELL HEALTH PLAN
YOU HAVE THE RIGHT TO APPEAL

Important Information about Your Appeals Rights

What if I need help understanding this denial? Contact us at (671) 477-5091 ext. 1120 if you need assistance understanding this notice on our decision to deny you a service or coverage. You can also email us at customercare@staywellguam.com.

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

How do I file an appeal? Follow the **Member Appeals Process** described in proceeding section. You will have six (6) months from the date of this notice to submit a written appeal to StayWell or its designee and initiate an internal review process with StayWell. You may request for an external review within four (4) months after the date of receipt of the result of your internal appeal or if you have an urgent appeal.

What if my situation is urgent? Expedited Internal Appeal. If your situation meets the definition of urgent under the law, your review will be conducted on an expedited basis. 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 by contacting our Customer Care Department at (671) 477-5091 ext. 1120. Urgent internal appeals will be processed within twenty-four (24) to seventy-two (72) hours.

Who may file an appeal? You or someone you name to act for you. You may authorize someone in writing by accomplishing StayWell's Authorized Representative Form. You can request for a copy of this form by contacting our Customer Care Department or by emailing customercare@staywellguam.com.

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Can I provide additional information about my claim? Yes, you may supply additional information. Please refer to the **Member Appeals Process** described in the proceeding section.

Can I request copies of information relevant to my claim? Yes, you may request copies by contacting us at (671) 477-5091 ext. 1120.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If your appeal is urgent, StayWell may provide its determination to you orally. Written notification will be sent to you within forty-eight (48) hours of any oral determination made. If we continue to deny the payment, coverage, or service requested or we do not comply with Federal Standards, or in the case of medical urgency you may be able to request an external review of your claim.

What is an external review? According to section 2719 of the Patient Protection and Affordable Care Act (PPACA), you have the right to request for external appeal so that your claim can be examined by an independent third party who will then review the denial and issue a final determination. StayWell is required to follow the provisions of the law, as well as the Interim Procedures for Federal External Review as described in the Technical Guidance released by the Department of Health and Human Services (HHS) until further guidance is issued by HHS. If you have an urgent claim, you may, orally or in writing, also request for an expedited external review.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

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MEMBER APPEALS PROCESS

If you were denied coverage or payment for a requested service, or supply and you disagree with our decision, you may follow this appeals process.

A. Appeal to StayWell in writing to reconsider initial decision. You should:

- Write to StayWell's Appeals Committee within six (6) months from the date of StayWell's decision or Accomplish StayWell's Appeal Form; and
- Send your appeal to StayWell at: 520 Route 8 Maite, Guam 96910; and
- Explain why you believe the initial determination should be reconsidered, based on the benefit provisions in your health plan; and
- Attach documents supporting your explanation including medical records, physician letters, bills, receipts and any other form that would serve the same purpose.
- File for an expedited internal appeal in urgent care situations by contacting out Customer Care Department at (671) 477-5091 ext. 1120. Urgent internal appeals will be processed within twenty-four (24) to seventy-two (72) hours.

B. The Appeals Committee has thirty (30) days from the date it received your Pre-Service Appeal and sixty (60) days from the date it received your Post-Service Appeal to:

- Authorize coverage for the requested service, or supply.
- Request for more information from you or your provider – Proceed to Step C; or
- Write to inform you that the denial is maintained Proceed to Step D.

C. You or your provider should send the information so that the Appeals Committee will receive it within forty-five (45) days of our request. The Committee will then decide within 30 more days.

If information is not received within 45 days, the Appeals Committee will decide within 30 days from the date the information was due. The decision will be based on available information. The Appeals Committee will write to you about the decision.

D. If you do not agree with the Appeals Committee's decision, you can file an External Review. Proceed to Step E.

E. Almost always, issues find resolution within the first level of appeal. Otherwise, you may seek arbitration or request for standard or expedited external review. For more information regarding this, you may contact StayWell's Customer Care Department at (671) 477-5091 ext. 1120.

F. Standard external review. If we continue to deny the payment, coverage, or service requested or we do not comply with Federal Standards, or in the case of medical urgency, 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. Per the interim external review guidelines issued by HHS, this process will be administered by MAXIMUS Federal Services. Within four (4) months after receipt of a denial of coverage or service, request for an external review by submitting an online request at externalappeal.cms.gov, under the "Request a Review Online" heading, or in writing by faxing the request to 1-888-866-6190, or by sending it by mail to: MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534. You may submit additional written comments to the external reviewer, though any submitted information will be shared with us to give StayWell an opportunity to reconsider the denial. If you have any questions or concerns during the external review process, you can call MAXIMUS at the toll-free number 1-888-866-6205 or contact the Guam Department of Revenue and Taxation, Regulatory

Division at (671) 635-1844-45 or 635-7664 .

When the examiner, designated by MAXIMUS, receives an external review request, the examiner will contact StayWell. Within five (5) business days of receipt of request by the examiner, StayWell will provide to the examiner all of the documents and any information considered in making the Adverse Benefit Determination or final internal appeal decision

Within forty-five (45) days after receipt of the request for external review, the examiner will provide you and StayWell a written decision. If the decision of the examiner includes reversal of the denial of coverage or service, StayWell will immediately comply.

G. Expedited external review. In urgent care situations, e.g. when the expedited/urgent internal appeals process timeframe would seriously jeopardize your life and health or would jeopardize your ability to regain maximum function, you may request for an expedited external review by selecting "expedited" if submitting the review request online, or by emailing FERP@MAXIMUS.com, or calling Federal External Review Process at 1-888-866-6205 ext. 3326. If you have an urgent health situation, you can file for an external appeal, orally or in writing, at the same time as your request for an internal appeal.

The examiner, designated by MAXIMUS, must provide notice of the expedited external review decision as promptly as your medical conditions or circumstances require, but no more than seventy-two (72) hours after receipt of the request for an expedited external review. The examiner will provide you and StayWell with an oral or written decision. Any decision provided orally by the examiner will be followed by a written notice within forty-eight (48) hours.

If you do not agree with the final determination on your internal or external appeal, you have a right to bring a civil action under Section 502(a) of ERISA, if applicable.

ISLAND HOME INSURANCE COMPANY STAYWELL HEALTH PLAN NOTICE OF PRIVACY ACT RIGHTS

In order to adjudicate an external review under the external review process administered by the U.S. Department of Health and Human Services (HHS), HHS requires you to submit a form (provided to you by StayWell), with your name, health insurance ID number, phone number and mailing address as well as your insurer's name and the claim number. Omitting any information that is necessary to decide your external review will mean that your external review will not be conducted.

MAXIMUS, the federal contractor that conducts the federal external review process for HHS, will use your information principally to adjudicate you appeal, provide you or your insurer with a record of appeal, and general management of the appeals review system. HHS and MAXIMUS will use this information to initiate an external review of your adverse benefit determination or final internal adverse benefit determination, to determine whether you are eligible for external review, to decide your appeal, and to track and report on the external review program). Other possible routine uses of your records include the following: responses to congressional inquiries initiated by you; for investigations of potential violations of law; for judicial or administrative proceedings where the Federal Government is a party to the administrative or judicial proceeding to another agency, a court, an administrative body, or to the Department of Justice, in connection with a proceeding when the information is arguably relevant to the proceeding; in the event of date breaches, for purposes of investigating the breach and mitigation response; to National Archives and Records Administration (NARA) or the General Services Administration (GSA) for records management purposes; to program and policy staff within HHS for statistical and analytical studies or to assist in formulating health program changes; and to researchers inside and outside of the Federal Government conducting research on insurance trends and topical issues.

HHS has the authority to regulate insurance benefits appeals and to administer this program under Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg-63, 330gg-91, and 330gg-92), as amended. HHS has discretion under the PHS Act in the manner in which it implements the HHS-administered external appeals process, and it has contracted with MAXIMUS to provide such services. Accordingly, MAXIMUS has authority to collect this information in order to administer external review on behalf of HHS.

Your Social Security Number (SSN) may be disclosed to MAXIMUS on some of the documents that you, your healthcare provider, or StayWell Insurance may submit as part of an appeal. MAXIMUS will send a copy of any information you send MAXIMUS to StayWell. This may include documents containing your SSN. Your SSN may be needed to identify your unique records.

Although disclosure of your SSN is not mandatory, failure to disclose it may prevent or delay the review of your claim. The authority for soliciting and verifying you SSN is Executive Order 9397.

StayWell INSURANCE

ISLAND HOME INSURANCE COMPANY
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THIS PAMPHLET CONTAINS NOTICE
OF PRIVACY ACT RIGHTS
MEMBER APPEALS PROCESS