IF YOU HAVE A COMPLAINT OR AN APPEAL

Complaints and Grievances

A **Complaint** is an oral expression of dissatisfaction with Us or with a Provider's service. Members may call the Member Services department to register a complaint. Complaints apply to any issue not related to a Medical Necessity or Experimental or Investigation determination made by Us. Complaints may be about claims processing, benefit choices, enrollment, or healthcare given to You by Your Provider.

A **Grievance** means a written complaint submitted by or on behalf of an enrollee regarding service delivery issues other than denial of payment for, or nonprovision of, medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

You are not required to file a complaint or grievance prior to seeking appeal of a decision or review of an adverse benefit determination.

Grievances are not adverse benefit determinations and do not establish the right to internal or external review of an issuer's resolution of the grievance.

To file a complaint, please call the Member Services number on Your ID Card.

For grievances received in writing, we will send a written response within 30 days.

Medical and Prescription Drug Appeals

In Writing: Wellpoint
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Wellpoint Vision Coverage Appeals

In Writing: Wellpoint Vision
Attention: Appeals
P.O. Box 9304
Minneapolis, MN 55440-9304

Appeals

An **Appeal** is a request to review a specific decision or an adverse benefit determination we have made.

An **Adverse-Benefit Determination** means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

You or your authorized representative, may file an Appeal regarding an adverse determination for requested healthcare services and supplies. Authorized Representatives are discussed further below. An Appeal may be done orally or in writing. A written Appeal must state plainly the reason(s) why the Member disagrees with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Appeal should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision, including getting a second opinion. Also, please include the following details with Your Appeal if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the three-letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You do not agree; and
- Any bills that You have received from the Provider.

An Appeal of an adverse determination must be sent within 180 calendar days of the date the finding was made unless there are special circumstances. We have the right to review the reason(s) for the delay and find out whether they warrant acceptance of the Appeal past the time frame.

Upon receipt of an Appeal, the following steps and actions take place:

1. We will provide you with notification that the appeal has been received.
2. We fully investigate and document the content of an Appeal and document Our findings. Investigation and documentation includes, but not limited to:
    a. The Member's reason for appealing the adverse determination;
    b. Additional clinical or other information provided with the Appeal request;
    c. Previous adverse determination or Appeal history;
    d. Follow-up activities associated with the adverse determination and conducted before the current Appeal.

3. We will make sure Your Appeal is reviewed by an appropriate reviewer. The reviewer will not have been involved in the initial adverse determination. We will also make sure they do not work for the person who made that decision. Any information You share with Us will be considered. If We need more information, We will get in touch with You. We may also contact Your doctor or any other Provider who may be able to help.

4. We will make a determination, and electronic or written notification of the determination is provided within 14 calendar days. Appeals of experimental and investigational denials are resolved within 20 calendar days, The decision notification deadline can be extended up to an additional 16 calendar days for good cause, without your consent, but notification of the extension will be sent to you.

5. The decision will include:
    a. The titles and information that qualifies the person or persons evaluating the Appeal;
    b. A statement of the reviewers' understanding of the reason for the Member's request for an Appeal;
    c. The reviewers' finding in clear terms and the reason in enough detail for the Member to respond to Our finding;
    d. A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Wellpoint in giving its first adverse determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
    e. The notice must advise of further external review/complaint rights provided to the Member.

6. We provide the Member, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member’s request. A document, record, or other information is considered relevant if such document, record, or other information:
    a. Was relied upon in making the benefit determination;
    b. Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the initial determination;
    c. Demonstrates that, in making the benefit determination, we consistently applied required administrative procedures and safeguards with respect to the Member as other similarly situated Members; or
    d. Constitutes a statement of policy or guidance with respect to the Policy concerning the adverse determination for healthcare service or treatment

for the Member's diagnosis, without regard to whether We relied upon the advice or statement in making the adverse determination.

7. Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, inpatient care and rehabilitation. If you appeal a decision that affects ongoing care because we've determined the care is no longer medically necessary, we will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

Expedited Appeals
If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received. A Member or Member's authorized representative has the right to request an expedited Appeal when, for example:

- You are currently receiving or has been prescribed treatment that would be stopped due to the determination.
- Your provider believes a delay in treatment could seriously harm the member's life, health, ability to regain function, or cause severe and intolerable pain.
- The issue involves admission, availability of care, continued stay, or emergency services, and You not been discharged from the emergency room or transport service.

Expedited reviews are not available if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness, or disease.

An expedited review may be submitted orally or in writing. To request an expedited Appeal, the Member, the Member's Provider, or the Member's authorized representative can contact Member Services at the phone number on the Member's Identification Card, fax the request to 855-298-4264 for medical or pharmacy or 877-487-7394 for behavioral health, or send a written request to:

Wellpoint
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

For expedited Appeals of adverse determinations, We make a determination and provide notification verbally, by facsimile, or other available similarly expeditious method, as soon as possible under the circumstances, and no later than 72 hours of the date of receipt.

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

External Review
External reviews are done by an Independent Review Organization (IRO). External review is available for Appeals that involve:

1. Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer.
2. Rescissions of coverage.
3. External appeals are available for decisions related to Wellpoint's compliance with protections against balance billing in accordance with federal and state law.

To initiate an external review:

- The internal appeal process must be exhausted before You may request an external review unless You filed a request for an expedited external review at the same time as an internal expedited appeal or We either provide a waiver of this requirement or fail to follow the appeal process.
- An external review request must be sent within 180 calendar days of receipt of the appeal notification. If external review is not requested, the internal review decision is final and binding.
- Collect any supporting documents that may help with your external review. This may include medical records and other information and send to:

  Wellpoint Grievances and Appeals
  Attention: External Review
  P.O. Box 105568
  Atlanta, GA 30348-5568

- We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
- For Urgent external reviews, the IRO will inform you of their decision immediately.
- If the IRO reverses our decision, we will apply their decision quickly.
- If the IRO agrees with our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

Expedited External Review
In addition to the above, an expedited external review may be requested if the adverse benefit determination or internal adverse benefit determination concerns:

- an admission, availability of care, continued stay, or health care service for which the claimant received Emergency Services but has not been discharged from a Facility; or

- involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

For urgent external reviews, the IRO will notify you of their decision immediately, but no later than 72 hours after receiving the request. If this notification is given verbally, they will also send a written notification within 48 hours after making the decision.

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your ID card.

Contact Washington Consumer Assistance Program at any time during this process if you have any concerns or need help filing an appeal.

Washington Consumer Assistance Program
5000 Capitol Blvd
Tumwater, WA 98501
800-562-6900
E-mail: cap@oic.wa.gov

Authorized Representative
You can choose someone to act for You or help You during the Appeal process. We call this "Member's authorized representative". They can be anyone – Your doctor, friend, relative, spouse, neighbor, attorney, etc. You must let Us know in writing if You want to choose a Member authorized representative. Send a letter to:

Wellpoint
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Please include the following details:
- Your name, ID number, date of birth and full address.
- The full name of the person You have chosen to act for You.
- That You are giving Us permission to share protected health information (PHI) with this person.
- The purpose for disclosing PHI to this person.
- A description of the specific information We can share.
- The date Your authorization expires.
- That You understand that You have the right to withdraw Your authorization at any time in writing.
- That You understand We are not responsible if Your Member authorized representative shares Your PHI with others.
- That You understand You are not required to provide authorization to receive treatment, payment, for enrollment or to be eligible for benefits.
- You must also sign and date the letter.