MAKING A LIVING WILL

By law, you may refuse care your provider wants to give you.

Here's how a living will or advance directive works. Sometimes people are very sick or hurt. Their provider may tell them or their families that death or something like a permanent coma may happen. By giving you some kinds of care, they can keep you living longer, but it will probably not improve your health. This care may include using machines that replace breathing or eating. Some people don't want to get that kind of care. But they know they may be too sick to refuse care. To make sure they get only the kind of care they want, they sign a living will. This paper says what kinds of care they want to refuse if death or something like a permanent coma happens.

You can sign a living will for yourself or your children. It will tell your provider what kinds of care you don't want if this happens to you. If you need help getting a living will, call Member Services at **833-731-2147 (TTY 711)**. Or download your state-specific living well form from caringinfo.org. You and your primary care provider (PCP) must work together to complete your living will. Give your living will to your PCP. Your PCP will make sure it's in your medical record. Then they will know how you want to be cared for if you're very sick or hurt very badly, and can't say what care you want.

You can change your mind after you've signed a living will. Call your Wellpoint PCP. They will help you take the living will out of your medical record. You can also make changes in the living will by filling out, signing, and dating a new one.

GRIEVANCES AND APPEALS

If you have a grievance

You may find yourself in a situation where you are not satisfied with something related to our plan. Some examples include:

- The quality of the care you have received from a plan provider;
- the way a plan provider or their staff have treated you;
- difficulty making an appointment with a specialist or other provider;
- difficulty getting authorization for services;
- our plan's policies; or
- the way our plan's staff have treated you.

If you are having any problems like these, you have the right to make a formal complaint to our plan. This is also called "filing a grievance." Our member grievance process allows us to get your feedback and make things right.

If you have a problem with your medical, dental, or Wellpoint services that do not involve denial of medical, dental, or other benefits, also called non-utilization management or non-UM services, call or write to us. You can also ask your provider and/or an authorized person to call or write to us for you. You can file a grievance by calling us toll free at **833-731-2147 (TTY 711)**. You can also write to us at the address

below:

Wellpoint
Quality Management Department
101 Wood Ave. S., 8th Floor
Iselin, NJ 08830
Phone: **833-731-2147 (TTY 711)**

If you write to us, please describe your grievance and provide contact information we can use to reach you, such as a phone number and email address. You can also request help through the **Grievance Form** on our website at **wellpoint.com/nj/medicaid/complaints-grievances**. A copy is also included on the following page in this member handbook, which you can fax to **877-271-2409** or email to **njmembers@wellpoint.com**. If you file a grievance with us in writing, we will send you a letter acknowledging that we received your grievance.

We will investigate your grievance and take action to resolve it within 30 (thirty) calendar days and send you a *Grievance Resolution Letter* to explain what we did to address this issue.

If you have any questions about this process, you can call us toll free at **833-731-2147 (TTY 711)**.

A Member Services representative will work with you to try to help fix your problem. If your problem isn't taken care of right away, we'll send you a letter or call you for more information.

If your grievance is urgent, we'll give you an answer within 72 hours of when we receive it.

GRIEVANCE FORM

First Name:	
Last Name:	
Member ID #:	
Best phone number to reach you:	
Your email address:	

What is the reason for your grievance (formal complaint)? Check the box for the issue that applies to you.

☐ **Difficulty making an appointment**

☐ **Dissatisfaction with the way a provider or their staff treated me**

☐ **A provider refused to see me because of claims payment issues with the plan**

If you chose one of the options above, specify provider:

_____

☐ **Difficulty getting services authorized**

☐ **I was billed for covered services**

☐ **Dissatisfaction with the way health plan staff treated me**

Additional Information (optional):

If we have denied your request for a treatment, item, or medication and you disagree with our decision, you can ask us to change it. That request is called an appeal. However, an appeal is different from a grievance. You can call us toll free at **833-731-2147 (TTY 711)** to file an appeal or if you have questions.

Have you contacted us before about this issue?	**Yes** ☐ **No** ☐
If yes, please give the date you contacted Member Services.	**Date: __/__/__**

If you file a grievance, Wellpoint won't hold it against you. We'll still be here to help you get care.

You, your provider, or authorized person can file a grievance orally or in writing with Wellpoint.

You have the right to file a grievance in your language. If you ask, we'll tell you in your primary language your rights to file grievances and will give the decision in your primary language. If you need help filing a grievance in your language, call Member Services at **833-731-2147 (TTY 711)**.

How to file a grievance

Level 1 grievance
To file a non-UM (Utilization Management) or non-medical/dental grievance, you, your provider, or authorized person can call us, write to us, or send us a fax. Tell us the problem, when it happened, and the people involved. Contact us at the address and phone numbers below:

Wellpoint
Quality Management Department
101 Wood Ave. S, 8th Floor
Iselin, NJ 08830
Phone: **833-731-2147 (TTY 711)**
Fax: **877-271-2409**

Once we get your grievance, we'll send you (and your provider or authorized person, if they made the request with your written consent) a letter within 15 calendar days to let you know we have your grievance. We'll ask you for more information, if needed. We'll try to solve the problem so you're satisfied.

We'll then send you (and your provider or authorized person, if they made the request with your written consent) a letter to let you know what our decision is within 30 calendar days from when you contacted us about your grievance. You can file another grievance with us about this problem if you're still not pleased.

Level 2 grievance
If you're still unsatisfied with the answer you got about your non-UM Level 1 grievance, you or your provider or authorized person has 60 days from the date of our response to file a Level 2 grievance with your written consent. To file a Level 2 grievance, you, your provider, or authorized person can call us, write to us, or send us a fax. Tell us the problem, when it happened, and the people involved. Contact us at the address and phone numbers listed in the last section, "Level 1 grievance."

We'll send you a letter within 30 calendar days of when we got your Level 2 grievance. This letter will tell you the final decision.

Utilization Management
Sometimes, we need to make decisions about how we cover your care and services. This is called Utilization Management (UM). The UM process or authorization for care may include looking at requests for health care or dental care to see if they are covered. Wellpoint follows the standards set forth by the National Committee for Quality Assurance (NCQA). All UM decisions are based solely on your medical or dental needs and available benefits. We do this for the best possible health outcomes for our members. Our policies don't discourage the use of services through the UM decision process. Providers and UM decision-makers don't get any type of reward if members don't use all the available services, or for denial of care or benefits.

Members can call for information about a specific UM service request. Language assistance for members to discuss UM issues in their primary language is provided, as well as TTY services for members who need them. Call us at **833-731-2147 (TTY 711)**. Member Services is available Monday through Friday from 8 a.m. to 6 p.m. Eastern time. Our representative will tell you their name, title, and that they work for Wellpoint.

Utilization Management Appeal Process: Service Denial/Limitation/Reduction/Termination based on Medical Necessity

You and your provider should receive a notification letter within two business days of any health plan decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, you (or your provider, with your written permission) can challenge it by requesting an *appeal*. See the summary below for the timeframes to request an appeal.

Stages	Timeframe for Member/ Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be Reached	FamilyCare Plan Type
Internal Appeal The **Internal Appeal** is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.	60 calendar days from date on initial notification/ denial letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the notification letter, **whichever is later**	30 calendar days or less from health plan's receipt of the appeal request	A /ABP B C D
External/IURO Appeal The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO).	60 calendar days from date on Internal Appeal notification letter	• On or before the last day of the current authorization; or • Within 10 calendar days of the date on the Internal Appeal notification letter, **whichever is later**	45 calendar days or less from IURO's decision to review the case	A /ABP B C D

Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	**Whichever is the latest of the following:** • On or before the last day of the current authorization; **or** • Within 10 calendar days of the date on the Internal Appeal notification letter, **or** • Within 10 calendar days of the date on the External/IURO appeal decision notification letter	A final decision will be reached within 90 calendar days of the fair hearing request.	A /ABP **only**

Initial Adverse Determination
If Wellpoint decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an *adverse determination*. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you or your provider (with your written permission) can challenge the decision by requesting an *appeal*. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call the plan at **833-731-2147 (TTY 711)**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time. Written appeal requests should be mailed to the following address:

Wellpoint
Appeals Department
P.O. Box 62429
Virginia Beach, VA 23466-2429

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

Internal Appeal

The first step of the appeal process is a formal internal appeal to the plan (called an Internal Appeal). Your case will be reviewed by a doctor, dentist, or another health care professional, selected by Wellpoint, who has expertise in the area of medical or dental knowledge appropriate for your case. We will be careful to choose someone who was not involved in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical or dental condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid state fair hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

Expedited (fast) Appeals
You have the option of requesting an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, if your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition, we must make a decision about your appeal within 72 hours.

Phone:	**833-731-2147 (TTY 711)**
Fax:	**877-271-2409**
Email:	**nj1memappeals@wellpoint.com**
Mail:	101 Wood Ave. S., 8th Floor Iselin, NJ 08830

External (IURO) Appeal
If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the *External Appeal Application* form. A copy of the *External Appeal Application* form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address within **60 calendar days** of the date on your Internal Appeal outcome letter:

Maximus Federal – NJ IHCAP
3750 Monroe Ave., Suite 705
Pittsford, New York 14534
Office: **888-866-6205**

You may also **fax** the completed form to **585-425-5296**, or send it by **email** to Stateappealseast@maximus.com.

If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call Member Services toll free at **833-731-2147 (TTY 711)** to request a copy.

External (IURO) Appeals are not conducted by Wellpoint. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either Wellpoint or the state of New Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical or dental condition makes it necessary).

You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the *External Appeal Application* form to Maximus Federal at **585-425-5296**, and ask for an expedited appeal on the form in **Section V, Summary of Appeal**. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal *within 48 hours*.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance at **888-393-1062** or **609-777-9470**.

The External (IURO) Appeal is optional. You don't need to request an External (IURO) appeal before you request a Medicaid state fair hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal *and/or* a Medicaid state fair hearing:

- You can request an External (IURO) Appeal, wait for the IURO's decision, and **then** request a Medicaid state fair hearing, if the IURO did not decide in your favor.
- You can request an External (IURO) Appeal **and** a Medicaid state fair hearing **at the same time** (just keep in mind that you make these two requests to different government agencies).
- You can request a Medicaid state fair hearing *without* requesting an External (IURO) Appeal.

Also, please note: Medicaid fair hearings are only available to NJ FamilyCare Plan A and ABP members.

Medicaid State Fair Hearing
You have the option to request a Medicaid state fair hearing after your Internal Appeal is finished (and the plan has made a decision). Medicaid state fair hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your **Internal Appeal outcome letter** to request a Medicaid state fair hearing. But if your appeal is about a pharmacy lock-in determination, you only have 20 calendar days to request a Medicaid state fair

hearing. You can request a Medicaid state fair hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

If you make an expedited (fast) Medicaid state fair hearing request, and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid fair hearing request.

Please note: The deadline for requesting a Medicaid state fair hearing is always 120 days from the date on the letter explaining the outcome of your *Internal Appeal*. This is true, even if you request an External (IURO) Appeal in the meantime. The 120-day deadline to ask for a Medicaid state fair hearing always starts from the outcome of your *Internal Appeal*, *not* your External (IURO) Appeal. Unless your appeal is about a pharmacy lock-in determination, then you only have 20 calendar days to request a Medicaid state fair hearing.

Continuation of Benefits
If you are asking for an appeal because Wellpoint is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. Wellpoint will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, **whichever is later**.

Your services will *not* continue automatically during a Medicaid state fair hearing. If you want your services to continue during a Medicaid state fair hearing, you must request that **in writing** when you request a fair hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; **or** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; **or**
- On or before the final day of the original authorization, **whichever is later**.

Please note: If you ask to have your services continue during a Medicaid state fair hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

If you have any questions about the appeal process, you can contact Member Services by calling **833-731-2147 (TTY 711)**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

OTHER INFORMATION

If you move

You should call **NJ FamilyCare** at **800-701-0710 (TTY 711)** if you're moving or planning to move. You can visit your County Welfare Agency if you're planning to move, too. If you're a NJ FamilyCare member, please call NJ FamilyCare at **800-701-0710 (TTY 711)** to give your new address. You may also call Member Services at **833-731-2147 (TTY 711)**.

If you're unable to leave your home

Wellpoint can help take care of you even if you can't leave your home. Call Member Services at **833-731-2147 (TTY 711)** right away if you're homebound. We'll have a care manager get in touch with you to make sure you get the care you need.

Renew your eligibility for your FFS, SSI, or NJ FamilyCare benefits on time

We want you to keep your health care benefits, including dental. You could lose your benefits even if you still qualify.

Every year, the NJ FamilyCare (NJFC) or the County Welfare Agency (CWA) will send you a form. This form tells you it's time to renew your FFS, SSI, or NJ FamilyCare benefits. Be sure to look at the due date on your form. You need to renew your eligibility on time. If your eligibility has ended, you'll no longer be enrolled in Wellpoint. Be sure to follow the NJFC or CWA rules about filling out the form. Turn it in before the date on your form. Your care manager or a Health Benefits Coordinator (HBC) can help you fill out the form. If you have any questions, call or go to the NJFC or CWA office in your area. These offices are listed on the next page. NJ FamilyCare members should:

- Call NJ FamilyCare at **800-701-0710 (TTY 711)** to renew their benefits.
- Complete and return the form previously sent by NJ FamilyCare as soon as possible. If you need a new form, call NJ FamilyCare at **800-701-0710 (TTY 711)**.

NJ FamilyCare members who are not Aged, Blind and Disabled (ABD) can fill out a renewal application online at njfamilycare.org/apply.aspx.

If you have questions about renewing your benefits, Wellpoint can help. Members should call **877-453-4080 (TTY 711)** with any questions about renewing eligibility. We want to help you keep getting your benefits if you still qualify. Helping you stay healthy is one of our main concerns.

If you have lost your NJ FamilyCare Medicaid eligibility, Wellpoint will send you a letter within 10 days of when NJ FamilyCare tells us this. The letter will tell you about