

Network Health Plan/Network Health Insurance Corporation's Grievance Process

A grievance is a written expression of dissatisfaction with Network Health Plan/Network Health Insurance Corporation's (NHP/NHIC) administration, claims practices or provision of services by NHP/NHIC, by or on behalf of a member. Written grievances received by NHP/NHIC are forwarded to NHP/NHIC's Customer Service Department for resolution.

GRIEVANCE PROCESS:

NHP/NHIC will acknowledge your grievance, in writing, within five (5) business days of receiving it. You will be notified at least seven (7) business days in advance of the time and date that the Grievance Committee will hear your case. You have the right to submit written comments, documents, records and other information relevant to your grievance. You have the option to appear in person before the Grievance Committee to present any additional information. If you are unable to attend in person, you may attend telephonically. You also have the right to have a representative attend on your behalf. NHP/NHIC's Grievance Committee will address your grievance and send you a written response within fifteen (15) calendar days for a pre-service grievance and thirty (30) calendar days for a post-service grievance. If NHP/NHIC cannot address your grievance within the noted time frame, due to circumstances beyond NHP/NHIC's control, we will notify you of the delay. The notice will state why more time is required and when you can expect the matter to be resolved. NHP/NHIC shall have an additional fifteen (15) calendar days for a pre-service grievance or thirty (30) calendar days for a post-service grievance to complete your grievance.

- ✓ **IMPORTANT:** NHP/NHIC may obtain medical advice and/or medical review when necessary and appropriate to evaluate your grievance.

RIGHT TO REQUEST AN INDEPENDENT REVIEW:

You may have the right to have an independent review of certain final decisions made by NHP/NHIC. If you (or a representative on your behalf) request an independent review, an Independent Review Organization (IRO) will process your grievance. An IRO is not connected in any way with NHP/NHIC and is certified with the State of Wisconsin. The IRO decision is binding on both NHP/NHIC and the member.

Decisions made by NHP/NHIC that are eligible for review by an IRO are those where NHP/NHIC determined the requested care or service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. Requests for services that are not included in your benefit package are ineligible for independent review (including, but not limited to benefit limitations and direct exclusions).

Typically, you must complete NHP/NHIC's internal grievance process before you can initiate an independent review, however, you do not need to complete the grievance process if you need immediate medical treatment and the time period for completing the grievance process will cause a delay that could jeopardize your life or health or we agree with you that it is in everyone's best interest to proceed with your concern directly to independent review.

✓ **IMPORTANT:** To request an independent review, you must send your written request to NHP/NHIC within 120 days (4 months) from the date of the final notification. If you do not notify NHP/NHIC of your request for independent review within the 120 days, an independent reviewer cannot review your case. The written request must include:

- Your name, address, and telephone number.
- The Independent Review Organization that you choose to review your case. A current list of certified IROs is available on the OCI's website at <http://oci.wi.gov>
- Explanation of why you believe the treatment/service should be covered.
- \$25.00 filing fee, made payable to the Independent Review Organization. If the IRO resolves the dispute in your favor the filing fee will be refunded to you.

✓ **IMPORTANT:** The total cost of the denied coverage must exceed \$274.00.

BINDING ARBITRATION:

If your grievance remains unresolved after completion of the grievance process, you may submit your grievance to binding arbitration as allowed by the Wisconsin Arbitration Act.

✓ **IMPORTANT:** Any costs of arbitration assessed by the member and NHP/NHIC will be apportioned equally between the two parties.

- ✓ **IMPORTANT:** Grievances reviewed by an Independent Review Organization are not eligible for binding arbitration.

EXPEDITED URGENT GRIEVANCE:

If your grievance involves clinical urgency or services for emergency conditions, the grievance will be expedited.

The grievance will be forwarded to the Quality Improvement Department for verification of clinical urgency. Urgent grievances will be reviewed and resolved within 72-hours. All urgent grievances will be investigated and responded to by a licensed nurse and/or physician. You will be notified, by telephone that your grievance is in progress. NHP/NHIC will also send you a written notice within twenty-four (24) hours acknowledging your grievance, and explaining your grievance rights. Once a determination has been made, you will be notified by telephone with an explanation of the decision. If you cannot be reached immediately, NHP/NHIC will contact your treating practitioner. NHP/NHIC will also send you written notification of the decision within seventy-two (72) hours following the determination.

ERISA:

As a participant in NHP/NHIC you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Once you have exhausted the grievance process, you have the right to file suit in Federal Court under Section 502(a) of ERISA.