IF YOU HAVE A COMPLAINT OR AN APPEAL

Complaint Process

A complaint is an oral or written 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.

To file a complaint, please contact Us at:

Wellpoint Grievances and Appeals

P.O. Box 105568
Atlanta, GA 30348-5568
Phone: Call the Member Services number on Your ID Card.

Appeals of Adverse Determinations and other Grievance Procedures

Appeals of Adverse Determination

An Adverse Determination is a coverage determination by Us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

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. 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 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.
2. 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.

3. 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.
4. We will make a determination and electronic or written notification of the determination is provided within a reasonable time frame appropriate to the medical circumstances. Pre-service Appeals are resolved within 30 calendar days and post service Appeals within 60 calendar days. 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.

Expedited Appeals of Adverse Determinations

A Member or Member's authorized representative has the right to request an expedited Appeal when the timeframes for a standard review could:

- Seriously jeopardize the Member's life or health;
- Jeopardize the Member's ability to regain maximum function; or
- Create an imminent and substantial limitation on the Member's existing ability to live independently if the Member has a disability.

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 within 72 hours of the date of receipt.

Grievance of Adverse Determination Decision

If You disagree with the decision, You may request a voluntary review of the grievance by an internal review panel. The review must be requested within 30 calendar days of Our final adverse determination notice. The panel will be persons who previously were not involved in the initial adverse determination. We shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.

External Review of Adverse Determination Appeals

Our members are offered two levels of Appeal for adverse determinations related to a service that requires medical review. An external review decision is binding on Us. An external review decision is binding on the Member claimant except to the extent the Member claimant has other remedies available under applicable federal or state law. We will pay for the costs of the external review performed by an independent reviewer.

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.

After exhausting Our internal review process, You can make a written request to the Grievances and Appeals Department for an external review after the date of receipt of Our internal response. We will send Your request to an Independent Review Organization (IRO). You must contact the IRO or Us within 120 calendar days (4 months) of the date of Your appeal resolution letter. If You do not file Your appeal for an external independent review within 120 calendar days, it cannot be reviewed. If You are not sure whether Your appeal is eligible, or if You want more information, please contact Us.

To initiate an external appeal:

1. The internal appeal process must be exhausted before You may request an external review unless You file 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.
2. We must allow You to make a request for an expedited external review with Us at the time You receive:
    a. An adverse benefit determination if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal expedited Appeal would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an internal expedited Appeal.
    b. A final internal adverse benefit determination, if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which You received emergency services, but has not been discharged from a facility.
3. You may request an expedited external review at the same time the internal expedited Appeal is requested and an IRO will determine if the internal expedited Appeal needs to be completed

before proceeding with the expedited external review.

Appeals related to Other Grievances

Other Grievances must be filed within one year of the occurrence (denial) unless it is concerning an adverse determination which may be reviewed by an internal review panel. This review must be requested within 180 days after Our transmittal of the final determination notice of an adverse determination. The members of the panel will not have been involved in the original coverage decision. However, a person who was involved in the original coverage decision, or a healthcare professional with appropriate experience, may answer questions relating to the grievance. The panel has the authority to bind Us to the panel's decision.

We will ensure that a majority of the persons reviewing a grievance involving an adverse determination are healthcare providers who have appropriate expertise. We shall issue a copy of the written decision of the review panel to the Member and to the healthcare Provider, if any, who submits a grievance on behalf of a Member. In cases of a denial of coverage, the reviewing healthcare provider shall not be a healthcare provider previously involved with the adverse determination.

We will provide a decision in writing within 60 calendar days after receipt of the grievance, or within a maximum of 90 calendar days if the grievance involves the collection of information outside the service area.

Authorized Representative

You can choose someone to act for You or help You during the Appeal process. We call this a "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.

Medical and Prescription Drug Appeals

Please refer to "Prescription Drugs" in the section “What is Covered” for the process for submitting an exception request for Drugs not on the Prescription Drug List.

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

Dental Coverage Appeals

[Please submit Appeals regarding Your dental coverage to the following address:

Wellpoint
P.O. Box 1122
Minneapolis, MN 55440-1122

Wellpoint Vision Coverage Appeals

Please submit Appeals regarding Your vision coverage to the following address:

Wellpoint Vision
P.O. Box 9304
Minneapolis, MN 55440-9304