IF YOU HAVE A COMPLAINT OR AN APPEAL

Complaints

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:
Member Services
Wellpoint
P.O. BOX 9041
Oxnard, CA 93031
Phone: call the Member Services number on Your ID Card.

You will receive an acknowledgement letter within five (5) days of receipt of the complaint. A response will be mailed to the Member within thirty (30) business days. We will investigate and resolve a complaint concerning an Emergency or a denial of continued hospitalization:

- In accordance with the medical or dental immediacy of the case; and
- Not later than one (1) business day after We receive the complaint.

Appeals Process of Complaint Resolution

You or Your authorized representative, if not satisfied with the resolution of the complaint, have the right to file a written request for Appeal. The Member has the right to appear in person before a complaint Appeals panel. You will receive an Appeal acknowledgement letter within five (5) days of receipt. We will complete this Appeals process no later than thirty (30) calendar days after the date the written request for Appeal is received.

An Appeal of a complaint relating to an ongoing Emergency or denial of continued hospitalization shall be concluded in accordance with the medical or dental immediacy of the case and not later than one (1) business day after the Member's request for an Appeal is received. At the request of the Member, We will provide, instead of a complaint Appeals panel, a review by a physician or Provider who has not previously reviewed the case and is of the same or similar specialty as the physician or Provider who would typically manage the medical condition or procedure under consideration for review in the Appeal.

The written request should be sent to the Grievances and Appeals address listed above.

Complaints to the Texas Department of Insurance (TDI)

A Member also has the right to file a complaint with the TDI:

Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-20301
Phone: 800-252-3439
Fax: 512-490-1007
Online: www.tdi.texas.gov

The health Plan will not engage in retaliatory action against an enrollee filing a complaint.

Adverse Determination Appeal Process

An adverse determination means a determination by the Plan that healthcare services provided or proposed to be provided to a Member are not Medically Necessary or are Experimental or Investigational.

If You are not satisfied with Our adverse determination, You must request an internal Appeal orally or in writing within 180 calendar days from the date You were notified of Our adverse decision.

You may initiate the internal Appeal by:

Verbally: Member Services at the number on Your ID Card

In Writing:

Wellpoint Grievances and Appeals Department
P.O. Box 105568
Atlanta, GA 30348-5568

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 acknowledgement letter will be sent to the appealing party within five (5) business days from receipt of an Appeal. The letter will advise if We need additional documents to consider the Appeal.

We will fully investigate and document the content of an Appeal and document Our findings. Investigation and documentation includes, but is not limited to:

- The Member's reason for appealing the adverse determination;
- Additional clinical or other information provided with the Appeal request;
- Previous adverse determination or Appeal history;
- Follow-up activities associated with the adverse determination and conducted before the current Appeal.

We will review the information to determine if it is sufficient to process the Appeal. If the information is not sufficient, We will request the additional information. We will review the Appeal and make a determination.

For Appeals concerning non-urgent adverse prospective and retrospective determinations, a decision will be made, and written notification of the decision will be provided within a reasonable timeframe appropriate to the medical circumstances, not to exceed thirty (30) calendar days from the date of receipt of the request for Appeal.

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. On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. In an Appeal of an adverse healthcare treatment decision, You have the right to review the claim file. More information may be submitted by or for the Member, any treating doctor, or Wellpoint as part of the internal Appeals process.

A finding will be made within thirty (30) days after We receive the request for an Appeal

Expedited Appeals

You may ask for an expedited Appeal if Your situation meets the definition of an expedited clinical Appeal. An "expedited clinical appeal" is an Appeal of a clinically urgent nature related to healthcare services, including but not limited to, prior authorization for treatment, denial of Emergency Care,

concurrent or continued hospitalization, prescription drugs or intravenous infusions.

Your Appeal will be reviewed by a healthcare Provider who has not previously reviewed the case and who is of the same or a similar specialty as the healthcare Provider who typically manages the medical condition, procedure, or treatment under review.

Upon receipt of an expedited Appeal, the health Plan will notify the party filing the Appeal as soon as possible, but in no event later than 24 hours after submission of the Appeal, of all information needed to review the Appeal. We will render a decision on the Appeal within 24 hours after We receive the requested information, but no later than 72 hours after the receipt of the Appeal. The Appeal notification will be followed with a letter within three working days of the initial telephonic or electronic notification.

Decision Letter Notification

The decision letter will include:

- The names, titles and information that qualifies the person or persons evaluating the Appeal.
- A statement of the reviewers' understanding of the reason for the Member's request for an Appeal.
- The reviewers' finding in clear terms and the reason in enough detail for the Member to respond to Our finding.
- 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.
- The notice will advise of the external review process to an Independent Review Organization (IRO) and how to initiate this review.

External Review

Members may request an Appeal to an IRO of a denial of an Appeal of an adverse determination made by the health Plan. If You wish to pursue external review, You or Your authorized representative must notify Our Grievance and Appeals Department in writing at the following address:

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

A written request must state plainly the reason(s) why You disagree with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The request 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 You feel may have a bearing on the decision. Also, please include the following details with Your request 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.

If someone else is filing on Your behalf, You will need to submit a statement signed by You, the Member, authorizing that person to be Your authorized representative.

We must receive the request within four months of the date that We denied Your Appeal. There is no

cost for this review.

If the circumstance involves a Member's life-threatening condition, or a circumstance involving the provision of Prescription Drugs or intravenous infusions for which the Member is receiving benefits under the EOC, the Member is:

- Entitled to an immediate Appeal to an IRO; and
- Not required to comply with procedures for an internal review of the Utilization Review agent's adverse determination.

Requesting an Expedited External Review

If the standard external review process would jeopardize Your life, health, or ability to regain maximum function, You may ask Us to expedite Your request for external review. If Your situation requires an expedited external review:

1. We will notify the IRO within one day and send them Your information.
2. The IRO will have two business days to review this material and request additional information. We will have two days to respond to this request.
3. Once the IRO has all the necessary information, it will make a decision within 72 hours.

You may also ask for an expedited external review if You are requesting a review of a decision that a recommended or requested service is Experimental/Investigative and Your doctor certifies in writing that the requested service would be significantly less effective if not promptly initiated.

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:

Grievances and Appeals Department 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.

The Importance of the IRO's Decision

The IRO will provide You, Your treating Provider, the Office of the Commissioner of Insurance, and Us a decision which shall include:

- The findings for either Us or You regarding each issue under review;
- The proposed service, treatment, Drug, device or supply for which the review was performed;
- The relevant provisions in the EOC and how applied; and

- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to IROs are handled as confidential records.

The decision of the IRO will be binding on Us and You except to the extent that there are remedies available under applicable State or federal law.

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 Attention:
Grievance and Appeals
Department 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