# Network Health Plan
# Grievance Process

A grievance is a written expression of dissatisfaction with Network Health Plan's (NHP) administration, claims practices or provision of services by NHP, by or on behalf of a member. Written grievances received by NHP are forwarded to NHP's appeal and grievance department for resolution.

## GRIEVANCE PROCESS

NHP will acknowledge your grievance, in writing, within five (5) business days of receiving it. You will be notified at least seven (7) calendar 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. Also, to comply with Federal Health Care Reform regulations, NHP will provide you with copies of any new or additional evidence considered, relied upon, or generated by NHP in connection with your grievance. NHP will provide this information, free of charge, in sufficient time to give you a reasonable opportunity to respond prior to the Appeals and Grievance Committee meeting. You have the option to appear in person before the Appeals and 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's Appeals and 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 cannot address your grievance within the noted time frame, due to circumstances beyond NHP'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 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 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. 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 and is certified with the State of Wisconsin. The IRO decision is binding on both NHP and the member.

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Decisions made by NHP that are eligible for review by an IRO are those where NHP determined the requested care or services do not meet NHP's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness, or experimental treatment, rescission of a policy or certificate, or coverage denial determination based on a pre-existing condition exclusion. Requests for services 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'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 within 120 days (four months) from the date of the adverse determination, experimental treatment determination or the date of the final notification, whichever is later. If you do not notify NHP of your request for independent review within the 120 days, an independent reviewer cannot review your case. The written request must include the following.

    - 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 Office of Commissioner of Insurance (OCI) website at **oci.wi.gov**.
    - Explanation of why you believe the treatment/service should be covered.

**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 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 a licensed nurse and/or physician 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 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 will contact your treating practitioner. NHP will also send you written notification of the decision within seventy-two (72) hours following the determination.

**ERISA**

As a participant in NHP 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.

You may have other voluntary dispute resolution options, such as mediation. To find out what may be available contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

**RIGHT TO REQUEST CLINICAL REVIEW CRITERIA**

Upon request you can obtain, free of charge, a copy of the actual benefit provisions, guideline, protocol or other similar criteria on which the grievance decision was based. Network Health Plan decisions for which you may request clinical rationale and clinical review criteria are those where NHP determined that the requested care or services are not medically necessary. Additionally, you can obtain reasonable access to, and copies, free of charge, of all documents relevant to your grievance.