1570 Midway Pl.
Menasha, WI 54952

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

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You have the right to:

1. Appeal an "Adverse Benefit Determination" under Section 1 (as described below), the "Standard Appeals Process." An Adverse Benefit Determination is any denial, reduction, or termination of a benefit (including any failure to make payment, in whole or in part, for a benefit) and any rescission of coverage.

2. Appeal an Adverse Benefit Determination under Section 2 (as described below), the "Expedited Review Process," if the Adverse Benefit Determination:
    a. Will result in serious jeopardy to your life or health or to your ability to regain maximum function;
    b. Will, in the opinion of a physician with knowledge of your medical condition, cause you to be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination; or
    c. Should, in the opinion of a physician with knowledge of your medical condition, be reviewed on an expedited basis.

3. Have NHP/NHIC review any other type of Grievance under Section 3 (as described below), the "Grievance Process." A Grievance is (a) any expression by (or on behalf of) a member of dissatisfaction with NHP/NHIC's provision of services or claims practices or (b) reformation of a policy.

Network Health Plan/Network Health Insurance Corporation's (NHP/NHIC's) Appeals and Grievance Team will review your appeal or grievance.

ü **IMPORTANT:** To submit an appeal of an Adverse Benefit Determination or a Grievance, send a written explanation of your appeal or Grievance with your name, Member number, and contact information to:

Network Health Plan
Attn: Appeals and Grievance Specialist
P.O. Box 120
Menasha, WI 54952

- **IMPORTANT:** To submit a request for Expedited Review of an Adverse Benefit Determination, call a Member Experience Representative at 800-826-0940 or send a written explanation of your appeal with your name, Member number, and contact information to the address listed above or you may fax it to 920-720-1832.

- **IMPORTANT:** You are entitled to the following information about an appeal of your Adverse Benefit Determination free of charge. We will provide any new or additional evidence NHP/NHIC considers, relies upon, or generates in connection with your appeal and any new or additional rationale for denying your appeal; you may request reasonable access to and copies of all documents, records, and other information relevant to your appeal. NHP/NHIC will provide this information in sufficient time to give you a reasonable opportunity to respond prior to the Grievance Committee meeting. In addition, upon request, NHP/NHIC will identify for you any medical or vocational experts that NHP/NHIC consulted in considering your appeal.

- **IMPORTANT:** An Authorized Representative may act on your behalf with respect to a Grievance or appeal. Your authorized representative may be (1) a person who is authorized by law to act on your behalf; (2) your treating provider or a family member if you are unable to designate a representative; (3) a health care professional with knowledge of your medical condition (in the Expedited Review Process only); or (4) a person you designate in writing. Call a Member Experience Representative at 800-826-0940 to get an authorized representative designation form. In this Appeal and Grievance Process, "you" will mean you or your authorized representative.

- **IMPORTANT**: NHP/NHIC will consult with a health care professional who has appropriate training and experience in the relevant field of medicine when necessary and appropriate to evaluate your Grievance or your appeal of an Adverse Benefit Determination.

1. STANDARD APPEAL PROCESS

NHP/NHIC will acknowledge your appeal of an Adverse Benefit Determination, 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 appeal. 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.

After the hearing, the Grievance Committee will address your appeal and send you a written response within:

- Thirty (30) calendar days for an Adverse Benefit Determination that is a pre-service claim (*i.e.*, denial of a request for prior authorization of services); or
- Sixty (60) calendar days for an Adverse Benefit Determination that is a post-service claim (*i.e.*, a regular claim);

If you disagree with NHP/NHIC's written response to your appeal of an Adverse Benefit Determination, you may be able to request an independent review of the response. See Section 4, "Right to Request Independent Review." Alternatively, your appeal of our decision may be eligible for binding arbitration or other dispute resolution options. See Section 5, "Other Dispute Resolution Options."

2. EXPEDITED REVIEW PROCESS

NHP/NHIC's Quality Improvement Department will review your request for expedited review to verify that it meets clinical urgency standards. If your appeal qualifies, NHP/NHIC will expedite the review of your appeal of an Adverse Benefit Determination.

You will be notified by telephone that your Expedited Review of an Adverse Benefit Determination is in progress. NHP/NHIC will review and resolve your Expedited Review of an Adverse Benefit Determination as expeditiously as required by your medical condition, but in any event within seventy-two (72) hours. A licensed nurse, licensed physician, or both will investigate and respond to your Expedited Review of an Adverse Benefit Determination. NHP/NHIC will notify you by telephone of its determination concerning the Review. If you cannot be reached immediately, NHP/NHIC will contact your treating practitioner.

NHP/NHIC will also send you written notification of the decision with an explanation of the decision as soon as possible, taking into account the medical exigencies, but in any case within seventy-two (72) hours. NHP/NHIC will immediately mail (or e-mail) you a copy of your complete Certificate of Coverage upon receipt of a written request.

If you disagree with NHP/NHIC's written response to your Expedited Review of an Adverse Benefit Determination, you may be able to request an independent review of the response. See Section 4, "Right to Request Independent Review." Alternatively, your appeal of our decision may be eligible for binding arbitration or other dispute resolution options. See Section 5, "Other Dispute Resolution Options."

3. GRIEVANCE PROCESS

This Grievance process is only for concerns you have about NHP/NHIC that do not qualify as "Adverse Benefit Determinations" (see definition above). If your Grievance is an Adverse Benefit Determination, the process described in Section 1 or 2, above, will apply.

NHP/NHIC 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 questions, 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.

NHP/NHIC's Grievance Committee will address your Grievance and send you a written response within thirty (30) calendar days of receiving your Grievance. If NHP/NHIC cannot address your Grievance within thirty (30) calendar days, NHP/NHIC 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 will resolve the Grievance within an additional thirty (30) calendar days.

If you are not satisfied with NHP/NHIC's resolution of your Grievance, your Grievance may be eligible for binding arbitration or other dispute resolution options. See Section 5, "Other Dispute Resolution Options."

4. RIGHT TO REQUEST AN INDEPENDENT REVIEW

The only appeals that are eligible for independent review are appeals of Adverse Benefit Determinations (including Expedited Reviews of Adverse Benefit Determinations) that involve:

- Medical judgment, including NHP/NHIC's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or NHP/NHIC's determination that a treatment is experimental or investigational.
- Rescission of your policy or certificate.
- Denial of a request for referral for out-of-network services that are medically necessary for your treatment but that may not be available in NHP/NHIC's provider network.

Requests for services that are not included in your benefit package are not eligible for independent review (including, but not limited to, direct exclusions).

Generally, you must complete NHP/NHIC's internal appeal process before you can initiate an independent review. You do not need to complete the internal appeal process, however, if your Adverse Benefit Determination qualifies for the Expedited Review Process and you request an immediate independent review. In addition, if you request immediate independent review, we may agree to proceed if we conclude that it is in everyone's best interests.

To request an independent review, you must send your written request to NHP/NHIC within four (4) months of the date on which you receive NHP/NHIC's written response to your appeal or the Adverse Benefit Determination, whichever is later. If you do not notify NHP/NHIC of your request for independent review within four (4) months, your case is no longer eligible for independent review. Your written request must include:

- Your name, address, and telephone number.
- An explanation of your disagreement with the Adverse Benefit Determination.

In an urgent care situation, your request for independent review does not have to be in writing and will be expedited; you may also request to have the Grievance Committee review an urgent care situation at the same time as the IRO to save time. When NHP/NHIC receives your request for independent

review, NHP/NHIC will perform a preliminary review to determine whether your request is eligible for review. NHP/NHIC will complete the preliminary review within five (5) business days (as soon as possible for an Expedited Review) and notify you of its determination within one (1) additional business day (as soon as possible for an Expedited Review). If your request is not eligible for independent review, NHP/NHIC will explain the reasons why it is not eligible and any information you may provide to make your request eligible. If your request is eligible for independent review, NHP/NHIC will randomly assign your case file to one of three contracted Independent Review Organizations (IROs) to process your appeal. Each IRO with which NHP/NHIC contracts is accredited with a nationally recognized accrediting organization.

- For standard reviews, the IRO must make a decision and notify NHP/NHIC and you in writing within forty-five (45) days of receiving the independent review request.
- For expedited reviews, the IRO must make a decision and notify NHP/NHIC and you within seventy-two (72) hours of receiving the independent review request. The IRO may notify you orally or in writing. If the IRO informs you of its decision orally, it must provide you with a written response within an additional forty-eight (48) hours.

NHP/NHIC will mail (or e-mail) you a copy of your complete Certificate of Coverage within three (3) business days of receipt of a written request.

Generally, the IRO's decision is binding on both NHP/NHIC and you, except to the extent other remedies are available under State or Federal law. If the Adverse Benefit Determination involved in the decision relates to a preexisting condition exclusion or the rescission of coverage, however, the decision is not binding on you. In that case, you may be eligible for other dispute resolution options. See Section 5, "Other Dispute Resolution Options."

5. OTHER DISPUTE RESOLUTION OPTIONS

You may have other voluntary dispute resolution options, such as mediation, or binding arbitration. To find out what may be available, contact NHP/NHIC's Member Experience Team at 800-826-0940; your local U.S. Department of Labor Office; or the Wisconsin Office of the Commissioner of Insurance at 800-236-8517.

If your Grievance or appeal of an Adverse Benefit Determination remains unresolved after completion of this Process, you may submit your Grievance or appeal of an Adverse Benefit Determination to binding arbitration as allowed by the Wisconsin Arbitration Act.

In addition, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). If ERISA applies to your employer's plan, once you have exhausted the grievance process, you may have the right to file suit in Federal Court under Section 502(a) of ERISA.

ü **IMPORTANT:** Any costs of arbitration will be apportioned equally between you and NHP/NHIC.

- **IMPORTANT:** Adverse Benefit Determinations reviewed by an Independent Review Organization are not eligible for binding arbitration, except for Adverse Benefit Determinations that relate to preexisting condition exclusions or the rescission of coverage.