GRIEVANCE PROCEDURES

In Accordance with Chapter 632.83 of the Wisconsin Insurance Code and Ins. 18 of the Wisconsin Administrative Code

Please read this notice carefully for important information about how to file grievances with us. You have the right to ask us to review our decisions involving your pre-treatment benefit estimates or claim payments. You also have the right to contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

A. Definitions

"Complaint" means any expression of dissatisfaction expressed to the insurer by the insured, or an authorized representative, about an insurer or the providers with whom the insurer has a direct or indirect contract.

"Covered Person" means the policyholder, claimant or their representatives, provider, agent or other entity which expresses a grievance or complaint involving the activities of the company or any persons involved in the solicitation, sale, service, execution of any transaction, or disposition of any funds of the policyholder.

"Grievance" means any dissatisfaction with the provision of services or claims practices of an insurer offering group or individual health insurance or administration of group or individual health insurance by the insurer that is expressed in writing to the insurer by, or on behalf of, an Insured.

"Expedited Grievance" means a grievance where any of the following applies:

(a) The duration of the standard resolution process will result in serious jeopardy to the life or health of the Insured or the ability of the Insured to regain maximum function.

(b) In the opinion of a provider with knowledge of the insured's condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) A provider with knowledge of the insured's condition determines that the grievance shall be treated as an expedited grievance.

B. Filing a Grievance

A grievance concerning any matter may be submitted to the following area:

Name: **Quality Control**
Address: **P.O. Box 82657**
Lincoln, Nebraska 68501-2657
Phone: **1- 877-897-4328 (Toll-Free)**
Fax: **1-402-309-2579**

C. Deadlines Applicable to the Grievance Review Process

We will send a written acknowledgment of receipt of your grievance within 5 business days. If the grievance was filed by your representative, our acknowledgement will note that health care information or medical records may be disclosed only if permitted by federal HIPAA and state laws.

We will review your grievance and send you a written response within 30 calendar days. Our response will include our decision, a description of the criteria and/or clinical reasons for that decision and any references to supporting documentation. We will also provide a copy of this information to your treating provider.

This time period may be extended an additional 30 days if we are unable to obtain necessary information from your provider or other person not affiliated with or under contract with us. If we need such an extension, we will send you a written notice explaining the reasons for the delay and the expected resolution date.

The time limit for filing a grievance with us will not be less than three years from the date of the benefit determination.

D. Grievance Committee

The grievance committee reviewing the grievance will not be the same person or persons who made the initial decision on the matter. You (or your representative) have the right to appear in person before the grievance committee to present oral or written information and to ask questions. We will inform you in writing of the time and place of the meeting at least 7 calendar days in advance. We will provide reasonable accommodations to allow such participation in the meeting.

E. Expedited Grievances

Any situations meeting the definition of an "expedited grievance" will be resolved as expeditiously as the Covered Person's health condition requires but not more than 72 hours after receipt of the grievance. Because no pre-authorizations are required under your policy, urgent requests or expedited grievances will likely only occur related to your elective requests for pre-treatment estimates of benefits.

F. Decision

(a) **Denial upheld**
If our decision is adverse to you, we will send you a written notice of that decision. This will be signed by a member of the grievance committee and will contain:

1. The names, titles and qualifying credentials of the person or persons participating in the grievance review process (the grievance committee).

2. A statement of the reviewer's understanding of the grievance and all pertinent facts.

3. The reviewer's decision in clear terms and the basis for the decision.

4. A reference to the evidence or documentation used as the basis for the decision.

5. Your right to contact the Commissioner's Office at the Wisconsin Department of Insurance to request assistance.

(b) **Denial reversed**
If we agree that a benefit should have been provided, or that a claim should have been paid, we will reissue the pre-treatment estimate or pay the claim.

G. Cultural and Linguistic Support

We want to be sure this information is helpful to you. We can provide interpreting services through our toll free Customer Service line shown in Section B. For Spanish only, you may call [1-800-487-5553] and speak directly to an employee who is proficient in the Spanish language. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print materials for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.