COMPLAINTS AND APPEALS

You have the right to complain about services offered through Chorus Community Health Plans or the *Practitioners* and *Providers* in *Our* network, or any other issue. *You* also have the right to file an *Appeal* when *You* are unhappy with a decision that has been made by *Us*. At any time during the course of the *Complaint* and *Appeal* process, *You* may choose to designate an *Authorized Representative* to participate in the *Complaint* and *Appeal* process on *Your* behalf. Appointment of representatives is completed in accordance with *Our* privacy policies.

A *Complaint* is an oral expression of dissatisfaction. *Complaints* can involve many different issues, including but not limited to the following:

- Access-appointment availability
- Attitude
- Billing and financial
- Quality of *Practitioner* office site: physical appearance, physical accessibility of office practice sites
- Concerns related to quality of care or discrimination
- Unprofessional treatment by professionals
- Medical record access and documentation
- Patient care clinical quality or outcomes
- Fraud, waste or abuse
- Privacy/HIPAA violations

WHAT TO DO IF *YOU* HAVE A *COMPLAINT*

Contact Customer Service at the telephone number shown on *Your* ID card. Customer Service representatives are available to take *Your* call during regular business hours, Monday through Friday. *We* will notify *You* of the outcome of *Our* investigation within 30 days.

***APPEALS* PROCESS**

An *Appeal* is a written request to review any decision regarding any *Complaint* or any *Adverse Benefit Determination*.

An *Adverse Benefit Determination* means any of the following:

- Any decision to rescind this *Contract*, and
- Any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *Benefit*, based on any of the following:
    - A determination of *Your* or *Your Dependent's* eligibility,
    - The application of any utilization review,
    - A determination that the item or service is for *Experimental or Investigational Treatment*
    - A determination that the item or services is not *Medically Necessary* or appropriate.

You or *Your* A*uthorized Representative* can file an *Appeal* within three years of *Our* decision concerning any matter. To file a formal *Appeal*, *You* or *Your Authorized Representative* should write down *Your* concerns and mail *Your* written *Appeal* (in any form) along with copies of any supporting documents to *Us*.

Your written *Appeal* can be emailed to [cchp-appeals@chorushealthplans.org] or mailed to the address listed below:

- Chorus Community Health Plans
  Attn: Appeals Department
  [P.O. Box 1997, MS 6280
  Milwaukee, WI 53201-1997]

We will send *You* a letter within five business days notifying *You* that the *Appeal* was received. *Our* acknowledgment letter will advise *You* of:

- *Your* right to submit written comments, documents, or other information regarding the *Appeal*,
- *Your* right to be assisted or represented by another person of *Your* choice,
- *Your* right to appear before the Appeals Committee in person or via teleconference. *You* will receive at least 7 calendar days' notice of the meeting.
- Availability of interpreter services during the *Appeal* process, for non-English speaking and hearing impaired members.
- How to contact *Us* for scheduling or to provide additional information.

We will review the *Appeal*, investigate, and provide *You* with a decision within 30 calendar days of receiving the *Appeal*. In some cases, an extension may be applicable and *You* will be notified accordingly. Notification will include when the resolution may be expected and why additional time is needed. The total time for resolution will be no more than 45 days from the date the *Appeal* was received.

WHAT TO DO IF *YOUR APPEAL* REQUIRES IMMEDIATE ACTION

A request for an urgent *Appeal* will be considered if the application of the time period for making a non-urgent determination:

- Could seriously jeopardize *Your* life or health or *Your* ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a *Practitioner* with knowledge of *Your* medical condition, would subject *You* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request, or
- If a physician with knowledge of the *Covered Person's* medical condition determines that the appeal shall be treated as an expedited appeal.

We will determine whether *Your* appeal qualifies as being urgent based on the aforementioned criteria. If it does, we will assign a nurse or *Practitioner* to investigate and respond to *Your Appeal*. If *Your* appeal does not meet the qualifications of being urgent, it will follow the standard timelines set forth above.

The request for an urgent *Appeal* does not have to be in writing. Urgent *Appeals* will be resolved within 72 hours after receipt, or sooner as needed to accommodate the urgency of the situation. *You* will receive both verbal and written notification of the decision.

To file an urgent *Appeal, You* may contact *Us* by phone at [1-877-900-2247] or send *Your* request via fax to [1-414-266-4195].

WHAT TO DO IF *YOU* DISAGREE WITH *OUR* DECISION

You may try to resolve *Your* problem by taking the steps outlined above in the *Complaints* and *Appeals* process. *You* may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a *Complaint*. *You* can contact the Office of the Commissioner of Insurance by writing to:

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

You can also call [1-800-236-8517] and request a *Complaint* form, or *You* can file a *Complaint* electronically with the Office of the Commissioner of Insurance at its website [http://oci.wi.gov/].

Please note that *Our* decision is based only on whether or not *Benefits* are available under the *Contract*. *We* do not determine whether the pending health service is necessary or appropriate. That decision is between *You* and *Your Practitioner*.

EXTERNAL REVIEW PROGRAM

When *We* have denied an *Appeal*, *You* may have the right to have *Our* decision reviewed by an independent review organization external to *Us*. *You* may file a written request for an external review within four months after the date of receipt of the notice of *Adverse Benefit Determination* or final internal *Adverse Benefit Determination*.

In order to qualify for an independent external review, one or more of the following criteria must be met as it relates to the *Adverse Benefit Determination.*

- Medical judgment, including *Our* requirements for *Medical Necessity,* appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or *Experimental/Investigational Treatment*.
- Denial of a request for *Out-of-Network* coverage when *You* feel the clinical expertise of an *Out-of- Network Provider* is *Medically Necessary.*
- Rescission of *Your* coverage.

You can submit an external review request through the Federal External Review Process portal at [https://externalappeal.cms.gov/ferpportal/#/requestReview]. This portal is the preferred method to request an external review.

If *You* decide not to submit *Your* request through the online portal, *You* can call toll free [1-888-866-6205] to request an external review request form. This form can be faxed to: [888-866-6190], emailed to [FERP@maximus.com], or mailed to the address listed below:

- Maximus Federal Services
  [3750 Monroe Ave, Suite 705
  Pittsford, NY 14534]

The information provided on the request form will be used to obtain the relevant documents from *Us. You* may also submit supporting information and documents. For example:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
- Letters *You* sent to *Us* about the issue; or
- Letters received from *Us* about the issue.

STANDARD REVIEW

When the external review examiner receives the external review request, the examiner will review the information provided by *Us* and may request additional information. The external review examiner will notify *You* in writing if it determines that *You* are not eligible for an external review.

The external review may be terminated if *We* decide to reverse *Our* decision and provide coverage or payment after reconsideration. *We* must provide written notice to *You* and the examiner within one business day after making the decision to reverse. The examiner must provide written notice of a final determination on the external review to *You* and *Us* as expeditiously as possible, but no later than 45 calendar days from the date of receipt of the request for external review.

The final external review decision notice will contain:

- A description of the reason for the requested external review with sufficient information to identify the claim;
- The date the examiner received the external review assignment;
- References to evidence or documentation considered in decision;
- Discussion of the reasoning for the decision including rationale and any evidence-based standards relied on;
- A statement that the decision is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available; and
- Current contact information for any applicable health insurance consumer assistance or ombudsman.

The examiner must maintain records of all claims and notices associated with the external review process for six years and make the records available for examination by *You* or *Us* upon request. Upon receipt of a final external review decision reversing the *Adverse Benefit Determination* or final internal *Adverse Benefit Determination, We* must immediately provide coverage or payment for the claim.

EXPEDITED EXTERNAL REVIEW

An expedited timeline is followed in cases where the claim meets the criteria set forth by federal guidelines. The examiner will notify *You* or *Us* as expeditiously as possible if the examiner determines that *You* are not eligible for external review.

The external review may be terminated if *We* decide to reverse *Our* decision and provide coverage or payment after reconsideration. *We* must immediately provide notice to *You* and the examiner after making the decision to reverse. This notice may be oral but must be followed up with written notice within 48 hours.

The reviewer shall make a final determination on the external review and communicate it to *You* and *Us* within 72 hours from the time of receipt of the request or sooner depending on medical circumstances of the case. If *You* are notified orally, the reviewer will follow-up with written notice within 48 hours after delivery of the oral notice. The examiner's final external review decision and records maintenance must comply with the same requirements as for final external review decisions in standard external review. Upon receipt of a final external review decision reversing the *Adverse Benefit Determination* or final internal *Adverse Benefit Determination*, *We* must immediately provide coverage or payment for the claim.

If *You* need technical assistance from the external review organization, call [1-888-866-6205]. *You* may leave messages and receive instructions on submitting expedited external review requests. TTY for hearing impaired, interpreters, and translated brochures are available upon request.