## XII. ADMINISTRATIVE SERVICES TO BE PROVIDED BY BCBSUW

C. Claim Determination and Appeal Procedures

1. Claim Appeal Procedure

   Any dispute about health insurance benefits or claims arising under the terms and conditions of the agreement shall first be submitted for resolution through BCBSUW's internal appeal process and may then, if necessary be submitted to the DEPARTMENT. The SUBSCRIBER may file a complaint with the Manager of Quality Assurance for review. The SUBSCRIBER may also request a departmental determination. The determination of the DEPARTMENT is final and not subject to further review unless a timely appeal of the determination by the DEPARTMENT is submitted to the BOARD, as provided by Wis. Stat. §40.03 (6) (i.) and Wis. Admin. Code § ETF 11.01 (3). The decision of the BOARD is reviewable only as provided in Wis. Stat. § 40.08 (12).

   If any SUBSCRIBER has a problem or complaint relating to a benefit determination, he/she should contact BCBSUW. This extends to any "carve-out" services (e.g., prescription drug administrators). BCBSUW will assist the SUBSCRIBER in trying to resolve the matter on an informal basis, and may initiate a Claim Review of the benefit determination. If the SUBSCRIBER wishes, he/she may omit this step and immediately file a Formal Appeal.

   Written inquiries received by BCBSUW <u>not</u> related to benefit determinations will be resolved by BCBUSW within an average of twelve (12) calendar days.

2. Claim Review

   A claim review may be done only when a SUBSCRIBER requests a <u>review</u> of denied benefits. When a claim review has been completed, and the decision is to uphold the denial of benefits, the SUBSCRIBER will receive written notification as to the specific reason(s) for the continued denial of benefits and of his/her right to file an appeal.

   - A CASE REVIEW OR CLAIM REVIEW MAY NOT BE SUBSTITUTED FOR A CLAIM APPEAL.
   - APPEALS REGARDING NON COVERED SERVICES OR SERVICES EXCLUDED BY THE CONTRACT MUST BE HANDLED LIKE ANY OTHER APPEAL.
   - APPEALS SUBMITTED BY A PROVIDER CANNOT BE REFERRED TO THE CLAIM APPEAL UNIT.

3. Departmental Request for Grievance

   The DEPARTMENT may require BCBSUW to treat and process a complaint received by the DEPARTMENT as a grievance as appropriate, if the DEPARTMENT forwards the complaint to BCBSUW on behalf of the member. BCBSUW shall process the complaint as a grievance in compliance with the Health Benefit Plan General Conditions regarding Formal Grievance.

3~~. Urgent Health Concerns~~

   ~~Appeals related to an urgent health concern (i.e., life threatening), will be handled within four (4) business days of BCBSUW's receipt of the Appeal.~~

4. Internal Grievance Process

   a. The Group Insurance Board directs that the internal grievance process comply with Wis. Stats. § 632.83, except as may otherwise be expressly provided to the contrary in the CONTRACT and AGREEMENT. An insured shall have the option of requesting independent review from an organization certified by the Commissioner of Insurance under Wis. Stats. § 632.835 (4) in the same manner and following the same timelines and

procedures as provided by Wis. Stats. § 632.835 and Wis. Admin. Code ch. Ins 18 except as may be otherwise provided or modified by the Group Insurance Board in the terms of the contract. However, BCBSUW shall not be in breach of this AGREEMENT solely because the independent review organization (IRO) does not comply with the timeframes set forth in the statutes or regulations.

b. Should a subscriber request an external review, the administrator shall make payment for reasonable fees required to be paid to the IRO by the insurer. Payment for such review shall be reimbursed to the administrator on a cost basis.

4. ~~Formal Appeal~~

~~The Appeal request must be received by BCBSUW within 60 days after the SUBSCRIBER was sent written notice regarding the claim. The request may be in any form, but:~~

~~1.Must be in writing;~~
~~2.Should be identified as a grievance or Claim Appeal;~~
~~3.Should specify the date of service, the patient name, amount, and any other identifying information such as the claim number or health care provider, as shown on the denial; and~~
~~4.Should provide any other pertinent information such as the identification number, patient's name, date and place of service, and reason for requesting review.~~

~~Investigation and resolution of any Appeal will be initiated within five (5) days of the date the Appeal is filed by the SUBSCRIBER in an effort to effect early resolution of the problem.~~

~~BCBSUW will acknowledge receipt of the Appeal within ten (10) calendar days. The SUBSCRIBER may appear in person before the Appeal Committee to present written or oral information. BCBSUW will notify the SUBSCRIBER of the time and place of the Appeal Committee meeting at least seven (7) calendar days before the meeting. The SUBSCRIBER may choose to attend the meeting by telephone, or may also choose to have another person present the Appeal on their behalf.~~

~~BCBSUW will review the Appeal. BCBSUW will provide a written decision, including reasons, within 60 days of receiving the Appeal. If special circumstances require a longer review period, BCBSUW will provide a written decision within 120 days of receiving the Appeal.~~

~~5. BCBSUW Appeal Committee~~

~~The Committee consists of at least three members. One member each will represent and have a background in the field of medicine, law and company operations. Each member will have an alternate with expertise in the discipline they represent. Committee membership may change from time to time; however, each of the three disciplines will be represented whenever the Committee meets.~~