Complaints & Appeals Policy

I. GENERAL

A. Complaints and Appeals

1. Complaints: If you have a complaint about our services or about a benefit or coverage decision or any other WSHIP decision regarding your policy, please contact our Customer Service department. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. When you have a complaint, call or write our Customer Service department at 1-800-877-5187, PO Box 1090, Great Bend, KS 67530.

2. Appeals: If you are not satisfied with our response to a complaint or your complaint is a request that we reconsider our decision to deny, modify, reduce, or end payment, coverage or authorization of coverage, you will need to submit your complaint as a formal appeal. You or your authorized representative will need to request an appeal within 90 days of the event giving rise to the appeal. Following receipt of your appeal, we will let you know if we need more information to respond to your complaint. We will review your complaint and respond as soon as possible, but not more than 30 calendar days after receiving the information requested to review your complaint.

   To request an appeal, please send a written request to:
   WSHIP Appeals
   PO Box 1090
   Great Bend, KS 67530

   If your appeal relates to medical necessity review of services such as hospitalizations or outpatient therapies, you may send your request directly to our Utilization Management Department at: Utilization Management, PO Box 952679, Lake Mary, FL 32795-2679.

   If your appeal relates solely to prescription drug coverage, you may send your request directly to our Pharmacy Benefit Manager at: Express Scripts, 8111 Royal Ridge Parkway, Irving, TX 75063.

   Your appeal rights and the appeal process are described below. If you have questions about the appeal process, please contact our Customer Service department for assistance.

B. General Grievance and Appeal Rights

Any WSHIP applicant or participant who is aggrieved by an action or decision of WSHIP may pursue up to three levels of appeals. The first two levels are internal: first to WSHIP's administrator and second to WSHIP's grievance committee. The third level of appeal is external and may be made to a designated Independent Review Organization (IRO). IRO review is available only for appeals of decisions relating to the denial, modification, reduction, or termination of coverage of or payment for health care services. A person may appeal to the IRO only after completion of WSHIP's internal review process.

II. INTERNAL APPEAL PROCESS

A. Appeal to WSHIP's Administrator (First Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal within 90 days of the event giving rise to the appeal. We have delegated the administrator's responsibility for first-level appeals related to pharmacy benefit coverage issues to our Pharmacy Benefit Manager.

2. Within five business days, the WSHIP administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint, and the resolution requested.

3. WSHIP's administrator will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal.

4. WSHIP's administrator will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's administrator fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level.

5. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeal process timelines could seriously jeopardize the person's life, health or ability to regain maximum function, WSHIP's administrator will provide its written decision within 72 hours of receipt of the appeal request.

B. Appeal to WSHIP's Grievance Committee (Second Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal to WSHIP's grievance committee within 90 days of an adverse decision by WSHIP's administrator and include a written description of the complaint.

2. Within five business days, WSHIP's administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint, and the resolution requested. Within two business days of sending this notice, WSHIP's administrator will forward the appeal, with all relevant information from its files, to the WSHIP's grievance committee.

3. WSHIP's grievance committee will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of its receipt of the complete information needed to respond to the appeal. The grievance committee may engage independent medical and legal experts to assist in the review process.

4. WSHIP's grievance committee will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's grievance committee fails to make its decision within 30 days of its receipt of the complete information needed to

respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level (if applicable).

5. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health, or ability to regain maximum function, WSHIP's grievance committee will provide its written decision within 72 hours of its receipt of the appeal request.

III. EXTERNAL APPEAL PROCESS (Third Level)

A. If WSHIP's grievance committee affirms a decision to deny, modify, reduce, or terminate coverage of or payment for health services, the person may appeal the decision to an IRO by notifying the WSHIP administrator within 30 days of receipt of the grievance committee's written decision.

B. The administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving the person's request for appeal.

C. The IRO, made up of persons not associated with WSHIP, will review the complaint and make a decision. The IRO will provide its decision in writing to the person and WSHIP within 20 days of the person's request for appeal. WSHIP will pay the charges for the IRO's review and written report.

IV. SERVICES DURING APPEAL PROCESS

If the complaint is from a WSHIP enrollee contesting a coverage decision and such decision was based on a finding of no medical necessity, WSHIP will continue to provide the service until the appeal is completed. Upon completion of the appeal process, if WSHIP continued to provide the service in question and it is determined that the coverage was properly denied, WSHIP may charge the enrollee for the cost of the services provided.