MEMBER GRIEVANCES AND APPEALS PROCEDURES

We value our members. We want you to let us know right away if you are not happy with our health plan. This includes if you have any questions, complaints or problems with your covered services or the care you receive. If at any point you need help doing this in another language or alternate format, give us a call. In this section we will tell you how you can let us know about these concerns.

If you file a grievance or an appeal, we must be fair and cannot make you leave our health plan or treat you poorly.

If you file a grievance or appeal regarding dental care you've received through Liberty Dental Plan, our WellCare of New Jersey Grievance and Appeals teams will work on your request.

GRIEVANCES

A grievance, sometimes called a complaint, is when you tell us you are not happy with us, a provider or a service. Grievances may be about, but not limited to:

- Quality-of-care issues;
- Wait times during provider visits;
- The way your providers or others act or treat you;
- Unclean provider offices; or
- Not getting the information you need.

You can file a grievance by calling or writing to us. To file by phone, call Member Services at **1-888-453-2534**. TTY users may call **711**.

To write us, mail to:
WellCare
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

You can file your grievance yourself or have someone file it for you. This includes your Primary Care Provider or another provider. We must have your written consent before someone can file a grievance for you. You may file your grievance at any time. You can find forms to file a grievance or appeal on our website.

You can file a grievance orally or in writing.

Do you need help filing a grievance? Call Member Services at **1-888-453-2534**. TTY users may call **711**.

Within five business days of getting your grievance, we will mail you a letter letting you know that we received your grievance. We will then make a decision about your grievance within 30 days. We will mail you a letter with our decision.

WellCare® Health Plans

CAD_02039E State Approved 10122017

092-17-47

NJ7CADINS02039E_0000

APPEALS

UTILIZATION MANAGEMENT (UM) APPEALS

You can make a UM appeal when you do not agree with a decision we made based on medical necessity about your care. You can ask for a UM appeal when any of the following actions occur:

- We make an adverse determination under a utilization review program;
- We deny access to specialty and other care;
- We deny continuation of care;
- We deny a choice of provider;
- We deny coverage of routine patient cost in connection with an approved clinical trial;
- We deny access to needed drugs;
- We set arbitrary limits on medically necessary services;
- We deny payment for a benefit in whole or in part;
- We deny or limit authorization of a requested service, including the type or level of service;
- We reduce, suspend or end of a previously authorized service;
- We fail to provide services in a timely manner; and
- We deny a service based on lack of medical need.

You will get a letter from us when any of these actions occur. It is called a "Notice of Action letter " or "NOA letter." You can file a UM appeal if you do not agree with our decision. All UM appeals are reviewed by someone qualified to make these decisions.

INTERNAL UM APPEAL

You must file your UM appeal within 60 days of the date you get the NOA letter. You can file your appeal by calling **1-888-453-2534**. TTY users may call **711**. You can also file a UM appeal in writing. Send your appeal to the following address:

WellCare
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

If you request an internal appeal over the phone, you must follow up by writing to the address above.

You can file your appeal yourself, or have someone file it for you. This includes your PCP or another provider. We must have your written consent before someone can file an appeal for you. Our Member Services team can help you with your appeal if you need help.

We will review your appeal and send you a decision letter. If it is an emergency or you are in the hospital, we will decide your appeal within 72 hours. For all other internal UM appeals, we will decide your appeal within 30 calendar days. You or someone you choose to act for you can review all of the information we used to make our decision.

Active services will continue through the appeal process. You do not have to ask for a continuation of benefits to have them covered.

"FAST" OR "EXPEDITED" APPEALS

There may be times when you or your provider will want us to make a faster appeal decision. This could be because you or your provider thinks that waiting for the standard appeal time frame could seriously harm your health. (Standard time frames are 30 calendar days for an internal appeal.) If so, you can ask for a "fast" or "expedited" appeal.

You or your provider must call or fax us to ask for a fast appeal. Call Member Services at **1-888-453-2534**. TTY users may call **711**. Send a fax to **1-877-297-3112**.

You may also send us more information or provide comments for a fast appeal. The time frame to send this information is limited. This is due to the short time frame to process a fast appeal.

If your appeal was done over the phone, written notice is not needed. We will decide your appeal within 72 hours.

What if you ask for a fast appeal and we decide that one is not needed? In that case, we will:

- Change the appeal to the time frame for a standard resolution (30 calendar days for internal appeals);
- Make reasonable efforts to call you;
- Follow up with a written letter within 2 days to tell you that the appeal will be processed as a standard appeal; and
- Tell you over the phone and in writing that you may file a grievance about the denial of the fast appeal request.

ADDITIONAL INFORMATION

You or someone acting for you can give us more information if you think it will help your appeal. You can do this at any time during the appeal process. The time frame to send us more information is limited for fast appeals.

INDEPENDENT UTILIZATION REVIEW ORGANIZATION (IURO)

There is another step you can take if you are not happy with our internal UM appeal decision. An IURO appeal is an external appeal made by an Independent Utilization Review Organization (IURO) administered by the Department of Banking and Insurance (DOBI). If you want an external appeal, you must ask for it within 60-days after getting the adverse internal appeal determination notice.

The services below may not be eligible for the external (IURO) appeal process:

- Adult family care;
- Assisted living program;
- Assisted living services – when the denial is not based on medical necessity;
- Caregiver/participant training;
- Chore services;
- Community transition services;
- Home based supportive care;
- Home delivered meals;
- Personal Care Assistant (PCA) services;
- Respite (daily and hourly);
- Social day care;
- Structured day program – when the denial is not based on medical necessity; or
- Supported day services.

As with the other appeal steps, you or your PCP with your written consent can ask for an external appeal. To do this, follow these steps:

1. Fill out the External Application Form (we will send it to you with the Notice of Action letter)
2. Sign the form (this gives the IURO your permission to review your appeal information)
3. Mail the completed, signed form to:

New Jersey Department of Banking
Consumer Protection Services
Office of Managed Care
P.O. Box 329
Trenton, NJ 08625-0329

Once the IURO gets your form and appeal information, they will make a decision within 45 calendar days. You may think waiting 45 calendar days could harm your health. If so, you can call the Department of Banking and Insurance at **1-888-393-1062** to ask for a fast or expedited appeal (within 48 hours). (Even if you ask for a fast review, you will still need to complete the form mentioned above.) We will let you know the IURO's decision on your appeal within ten (10) business days of their decision.

We will accept the IURO's decision.

MEDICAID FAIR HEARINGS

NJ FamilyCare A and NJ FamilyCare ABP members have the right to a Medicaid Fair Hearing. If you are not sure if you are eligible, please call Member Services at **1-888-453-2534**. TTY users may call **711**. If you are eligible for a Medicaid Fair Hearing, you must request a Medicaid Fair Hearing in writing within 120 calendar days from the date you receive the adverse internal appeal decision. The 120 days include weekends and holidays. Someone you choose to act for you can ask for one also. Send your written request to:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712

OR

Fax the entire Medicaid Fair Hearing request, including the complete NOA letter to **609-588-2435**.

At the hearing, you can act for yourself. You may also have legal counsel, a relative, a friend or other person act for you. You will tell a judge from the Office of Administrative Law (OAL) why you think we made the wrong decision. We will give the reason for our decision, too. The judge will listen to both sides. He or she will give his or her opinion to Medicaid. Medicaid will then make the final decision.

CONTINUATION OF BENEFITS DURING INTERNAL AND EXTERNAL APPEALS

Your benefits will automatically continue during internal and external (IURO) appeals if all of the following conditions are met:

a. You or your provider filed the appeal on time;
b. The appeal involves ending, suspending or reducing treatment we allowed before;
c. A network provider ordered the service, and
d. The later of these two events:
   – You ask for the appeal while the previous authorization is still in effect, or
   – Within 10 days after we send the notice of adverse benefit determination

The plan must send the notice of adverse benefit determination at least 10 calendar days before the end of the previously approved authorization. If we do not, we will extend the authorization to 10 calendar days after the notice was sent.

If you or your provider does not satisfy items "a" through "d" above, you may not be able to get a continuation of benefits. However, you will still have 60 days from receipt of the notice of adverse benefit determination to ask for an internal appeal.

For those eligible who request the Medicaid Fair Hearing Process, continuation of benefits must be requested in writing by the later of these two events:

- Within 10 calendar days of the date of the notice of action letter following an adverse determination resulting from an internal or external (IURO) appeal, or
- On or before the final day of the previously approved authorization

Duration of Continued or Reinstated Benefits: The Plan will continue the member's benefits while an appeal or Fair Hearing is pending until one of the following occurs:

a. The member withdraws the appeal or request for Medicaid Fair Hearing;

b. The member fails to request a Medicaid Fair Hearing and continuation of benefits within 10 calendar days after the Plan sends the notice of adverse resolution of the member's external appeal; or

c. A Medicaid Fair Hearing decision is not in the member's favor

Sometimes the Plan or the State Fair Hearing officer will reverse a decision to deny authorization of services. If that happens and you got the services during the appeal, we must pay for those services.

ADDITIONAL HELP

You have the right, at any time.

NJ Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

Or you can call **1-800-356-1561**.

You should also check the Frequently Asked Questions on the NJ FamilyCare website for more information.

WellCare Health Plans complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-888-453-2534**. For TTY, call **711**.

Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle información en otros formatos. Estos incluyen braille, audio y letra de imprenta grande. Simplemente, llámenos sin cargo al **1-888-453-2534**. Para TTY llame al **711**.

如果中文是您的母語，我們可以為您翻譯。我們也可以用其它格式為您提供資訊。這些格式包括布萊葉文、音頻及大字體。僅需撥打我們的免費電話。您可以撥打 **1-888-453-2534** 聯絡我們。TTY 用戶請撥打 **711**。