

**FEDERATED MUTUAL
INSURANCE COMPANY**

HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GRIEVANCE AND APPEAL PROCEDURES

1. SUBMISSION OF GRIEVANCES

Initial grievances based on our utilization review organization's (named on the back of the identification card provided to covered persons) denial of a pre-certification request under the policy's precertification requirements should be submitted to the utilization review organization as directed in their non-certification letter.

All other initial grievances should be submitted to the Medical Benefits & Services Appeals Department at:

Medical Benefits & Services Appeals Dept
Federated Mutual Insurance Company
Mail Code HC01
P.O. Box 991
Owatonna, MN 55060
Fax: 507-446-4698
E-mail: healthappeals@fedins.com
Toll-free: (800) 533-0472

After that first review is completed, a second level grievance can be submitted to our Medical Benefits & Services Appeals Department. A covered person can also contact the local U.S. Department of Labor Office or insurance regulator in their state to submit a grievance or complaint.

A covered person can appoint an authorized representative to act on his behalf in pursuing a grievance. Except for a grievance related to an emergency condition, the appointment of an authorized representative for handling grievances must be in writing and signed by the covered person. An assignment of benefits to a provider is not appointment of an authorized representative for grievances.

Initial grievances must be submitted within 180 calendar days of the event giving rise to the grievance. The event giving rise to the grievance can be a notice of benefit determination, a notice of rescission of coverage, an administrative action by us or the provision of another service by us. For a grievance related to a notice of benefit determination or a notice of rescission of coverage, the date of the event is receipt of the notice. Notices sent by U.S. Mail are presumed to have been received 5 days after the notice was mailed. For a grievance related to an administrative action by us, the date of the event is the date we took the administration action. For a grievance related to the provision of another service by us, the date of the event is the date we provided the service.

Second level grievances must be submitted within 60 calendar days of the date printed on the written notice of the initial grievance decision.

Grievances can be submitted orally or in writing.

Information about internal and external grievance procedures may be found on the Indiana Department of Insurance website www.in.gov/idoi.

2. INITIAL GRIEVANCE PROCEDURE

When an initial grievance is received by our utilization review organization regarding treatment, services or supplies requiring pre-certification or the Medical Benefits & Services Appeals Department regarding all non-pre-certification issues, the following procedure will be used.

- a. Written or oral acknowledgment of the grievance will be sent or explained to the covered person and/or the authorized representative within 5 business days after receipt of the grievance. This shall include the name, address and phone number of the person handling the grievance and information on how to submit additional written material.
- b. The person reviewing the grievance will not be the same person who initially reviewed the claim.
- c. If the issue is clinical, the reviewer will consult a physician who was not involved in the initial review of the matter.
- d. The covered person will be provided with copies of any new or additional evidence or rationale considered, relied upon, or generated by us, prior to receiving a determination based upon new or additional evidence or rationale.
- e. An investigation into the substance of the grievance, including any aspects involving clinical care, will be completed by the reviewer and a decision made as expeditiously as possible but not more than 15 calendar days for a pre-service claim and not more than 20 working days for a post service claim. If the investigation and decision cannot be completed within 20 working days due to circumstance beyond our control, written notice will be sent to the covered person and/or authorized representative on or before the 20th working day. The written notice will include the specific reasons additional time is needed. The investigation will be completed within 30 total calendar days.
- f. The substance of the grievance and any actions taken will be documented by us;
- g. Written notice of the decision will be sent to the covered person and/or the authorized representative within 5 calendar days of the decision. This notice shall include:
 - i. the disposition of the grievance including the specific reason for the utilization review organization's or our decision and the right to appeal;
 - ii. the specific policy provisions applicable to the grievance;
 - iii. any internal guidelines used in making the decision;
 - iv. if the decision is based on medical necessity or the treatment being experimental or investigational, notice that the clinical basis for the decision will be provided on request;
 - v. information on how to obtain copies of documents the utilization review organization or we have on the grievance;
 - vi. information on how to file a second level grievance and a statement of the covered person's right to sue to recover benefits due under the terms of the policy, enforce rights or clarify rights to future benefits under the terms of the policy or for the plan administrator's failure or refusal to comply with a request for information required to be furnished by law;
 - vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."
 - viii. in states where the covered person has a right to review by the state regulatory agency, information on how to obtain that review; or
 - ix. information on the right to external review by an independent review organization.

3. SECOND LEVEL GRIEVANCE PROCEDURE

A second level grievance on any matter is initiated by sending a request for review to:

Medical Benefits & Services Appeals Department
 Federated Mutual Insurance Company
 Mail Code M-204

P.O. Box 328
Owatonna, MN 55060

Our Medical Benefits & Services Appeals Department will complete this review.

When a second level grievance is received by our Medical Benefits & Services Appeals Department, the following procedure will be used.

- a. Written or oral acknowledgment of the grievance will be sent or explained to the covered person and/or the authorized representative within 5 working days. This shall include the name, address and phone number of the person handling the grievance and information on how to submit written material.
- b. The person or panel reviewing the grievance will not include the same person who initially reviewed the claim or was involved in the first level grievance.
- c. If the second level grievance is based on an adverse determination due to the treatment, service, or supply being:
 - i. not appropriate or medically necessary; or
 - ii. experimental or investigationala panel of one or more qualified individuals will be appointed to resolve the appeal. The covered person has the right to appear in person or otherwise communicate with the appointed panel.
- d. The covered person will be provided with copies of any new or additional rationale or evidence considered, relied upon, or generated by us, prior to receiving a determination based upon new or additional evidence or rationale.
- e. An investigation into the substance of the grievance, including any aspects involving clinical care, will be completed by the reviewer as expeditiously as possible, reflecting the clinical urgency of the situation, and a decision made within 15 calendar days for a pre-service claim and within 30 calendar days for a post-service claim.
- f. The substance of the grievance and any actions taken will be documented by us;
- g. Written notice of the decision will be sent to the covered person and/or the authorized representative within 5 calendar days of the decision. That notice shall include:
 - i. the disposition of the grievance including the specific reason for our decision and the right to request external review;
 - ii. the specific policy provisions applicable to the grievance;
 - iii. any internal guidelines used in making the decision;
 - iv. if the decision is based on medical necessity or the treatment being experimental or investigational, notice that the clinical basis for the decision will be provided on request;
 - v. information on how to obtain copies of documents we have on the grievance;
 - vi. a statement of the covered person's right to sue to recover benefits due under the terms of the policy, enforce rights or clarify rights to future benefits under the terms of the policy or for the plan administrator's failure or refusal to comply with a request for information required to be furnished by law;
 - vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."
 - viii. in states where the covered person has a right to review by the state regulatory agency, information on how to obtain that review; or
 - ix. information on the right to external review by an independent review organization.

4. EXPEDITED INTERNAL GRIEVANCE REVIEW

If the grievance relates to an emergency condition, an expedited initial or second level internal review can be requested orally or in writing. A covered person, authorized representative, or provider on behalf of a covered person can request expedited internal review by contacting us at the address listed above in INITIAL GRIEVANCE PROCEDURE or SECOND LEVEL GRIEVANCE PROCEDURE or by calling 877-612-4477.

A request for expedited external review by an Independent Review Organization (IRO) described in Expedited External Review Procedures below may be filed simultaneously with a request for the internal expedited review with us.

If the covered person, authorized representative, or provider requests an expedited review, an initial determination will be made as expeditiously as medical circumstances require but no later than 72 hours after receipt of the request. The determination may be issued orally with a written determination to follow within 48 hours after the oral notice is given. If the decision is adverse to the covered person, information about the right to request external review will be included with the written determination.

5. EXTERNAL REVIEW PROCEDURES

a. Standard External Review Procedures

The covered person has a right to request an external review of an “adverse determination” or “final adverse determination” by an Independent Review Organization (IRO) approved by the Indiana Insurance Commissioner (Commissioner).

i. The external review is only available after the completion of our internal grievance procedure unless:

- (1) the covered person has a medical condition where the timeframe to complete the internal grievance process would jeopardize the covered person’s life, health, or ability to regain maximum function; or
- (2) the denial is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person’s treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated; or
- (3) the covered person or the authorized representative has filed a standard appeal involving an “adverse determination” and has not received a written determination within 15 calendar days of our receipt of a pre-service claim or within 30 calendar days of our receipt of a post-service claim and the covered person has not consented to the delay; or
- (4) we and the covered person agree to waive the exhaustion requirement; or
- (5) the covered person or the authorized representative files a request for expedited external review at the same time a request for an expedited internal grievance review with us. The IRO assigned to conduct the expedited external review will determine whether the covered person shall be required to complete our expedited internal grievance review first.

External review of an “adverse determination” regarding a retrospective review cannot be filed until the internal grievance process is exhausted.

ii. To request an external review, the covered person and/or the authorized representative must send a written request for external review to the us at:

Medical Benefits & Services Appeals Department
Federated Mutual Insurance Company
Mail Code M-204

P.O. Box 328
Owatonna, MN 55060
Fax:507-446-4723
E-mail: healthappeals@fedins.com

- iii. External review must be requested within 120 days after the covered person or their authorized representative's receipt of an "adverse determination" or "final adverse determination."
 - iv. The covered person or their authorized representative must complete an authorization form allowing us to disclose the covered person's protected health information, including medical records that are pertinent to the external review.
 - v. The IRO will be assigned on a rotational basis. We will provide the IRO with all documents and information considered in making the determination being appealed within 5 business days of receiving the request for external review.
 - vi. The IRO may request additional information. If the covered person or the authorized representative submits additional information to the IRO, the IRO will forward the information to us within one business day.
 - vii. Within 15 business days after receipt of the request for external review, the IRO will make a determination. The IRO will issue written notice of its decision to uphold or reverse our "adverse determination" or "final adverse determination" within 72 hours of making the determination. The IRO will send the notice to the covered person, the authorized representative, and us.
- b. Expedited External Review Procedures

The covered person has a right to request an expedited external review of an "adverse determination" or "final adverse determination" by an Independent Review Organization (IRO) approved by the Commissioner when:

- i. the covered person receives an "adverse determination" and files a request for an expedited internal grievance review with us at the same time the external review request is filed with us:
 - (1) if the covered person has a medical condition where the timeframe to complete an internal expedited grievance review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - (2) if the "adverse determination" is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated. The request may be made orally.
- ii. the covered person receives a "final adverse determination":
 - (1) if the covered person has a medical condition where the timeframe to complete a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;
 - (2) if the "final adverse determination" concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility; or
 - (3) if the "final adverse determination" is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated. The request may be made orally.

- iii. To request an expedited external review, the covered person and/or the authorized representative must make a for external review to us in writing or orally at:

Medical Benefits & Services Appeals Department
Federated Mutual Insurance Company
Mail Code M-204
P.O. Box 328
Owatonna, MN 55060
Fax:507-446-4723
E-mail: healthappeals@fedins.com

- iv. Expedited external review must be requested at the time the covered person or their authorized representative receives an “adverse determination” or “final adverse determination” and include any additional or supporting documentation.
 - v. The covered person or their authorized representative must complete an authorization form allowing us to disclose the covered person’s protected health information, including medical records that are pertinent to the external review.
 - vi. The IRO will be assigned on a rotational basis. We will provide the IRO with all documents and information considered in making the determination being appealed immediately upon assignment.
 - vii. As expeditiously as the covered person’s medical condition circumstances require but no later than 72 hours after their receipt of the request for external review, the IRO make a determination and provide notice of its decision to uphold or reverse our “adverse determination” or “final adverse determination.” If the IRO provides its decision orally, it will follow up with the parties in writing within 48 hours. The IRO will send the notice to the covered person, the authorized representative, and us.
- c. For the purposes of this section:
 - i. “Adverse determination” means a determination by us or our utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and based on the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational and the requested service or payment for the service is therefore denied, reduced, or terminated. “Adverse determination” does not include a denial of coverage for a service or treatment specifically listed in the policy or certificate of coverage as excluded from coverage. A rescission of coverage is an “adverse determination.”
 - ii. “Final adverse determination” means an “adverse determination” involving a covered benefit that has been upheld by us or our utilization review organization at the completion of the internal grievance procedures.

6. RECORDKEEPING

We will maintain a record of all grievances filed and their resolution. The record will include the name of the covered person, date of the grievance, nature of the grievance, date of response/resolution and summary of the resolution. Copies of all grievances, investigative material, and response letters will be kept with the grievance record. The grievance record will be maintained in the claims office for a minimum of 6 years.

We will periodically review the grievance record. This review will include analysis of the appropriateness of responses.