

STATE OF INDIANA

INTERNAL AND EXTERNAL GRIEVANCE PROCEDURES

DEFINITIONS

As used in these procedures:

“Adverse Determination” means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated.

“External Grievance” means the independent review of a Grievance.

“Grievance” means any dissatisfaction expressed by or on behalf of an Insured Person regarding: (1) a determination that a proposed service is not appropriate or medically necessary; (2) a determination that a proposed service is experimental or investigational; (3) the availability of participating providers; (4) the handling or payment of claims for health care services; or (5) matters pertaining to the contractual relationship between: (a) an Insured Person and an insurer; or (b) a Policyholder and an insurer; and for which the Insured Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

INTERNAL GRIEVANCE PROCEDURES

In the event an Insured Person wishes to file a Grievance, the Insured Person or his designated representative may call us toll-free at [(800) 356-9601], or direct at: [(608) 238-2691] or by writing the company at: [Attn: Claims Operations Director, Carrier, Address Madison, WI 53705] within 180 days of claim denial.

The Grievance will be considered filed on the first date it is received either by telephone or in writing.

The company will acknowledge the individuals written or oral Grievance within 5 business days after receipt of the Grievance.

A decision on the Grievance will be made as soon as reasonably possible, but not more than 20 business days from receipt of the Grievance. If the company is unable to make a decision regarding the Grievance within the 20 day period, due to circumstances beyond the company’s control, the company shall: (1) notify, before the 20th business day, in writing, the reason for delay; and (2) issue a written decision regarding the Grievance within an additional 10 business days.

The company will notify the Insured Person in writing of the resolution of the Grievance within 5 business days after completing an investigation. The notice of resolution will include: (1) the companies understanding of the Grievance; (2) the decision reached by the company; (3) the reasons, policies, and procedures that are the basis of the decision; (4) a description of how to appeal the decision; and (5) the Insured Person’s right to call the representative listed below to obtain additional information about the decision or the right to appeal. The Covered Person has 180 days to appeal the Grievance decision.

[Carrier
Attn: Claims Operations Director
(608) 238-2691
Toll-free (800) 356-9601]

APPEAL OF GRIEVANCE DECISIONS

If the Insured Person wishes to appeal a Grievance decision, the Company or Utilization Review Entity will provide: (1) written or oral acknowledgement of the appeal request not more than 3 business days after the appeal is filed; (2) documentation of the substance of the appeal and the actions taken; (3) investigation of the substance of the appeal, including any aspects of clinical care involved; (4) notification to the Insured Person: (a) of the disposition of an appeal; and (b) that the Insured Person may have the right to further remedies allowed by law; (5) standards for timeliness in: (a) responding to an appeal; and (b) providing notice to the Insured Person of: (i) the disposition of an appeal; and (ii) the right to initiate an External Grievance review; that accommodate the clinical urgency of the situation.

In the case of an appeal of a Grievance decision of a determination that a proposed service: (1) is not appropriate or medically necessary; or (2) is experimental or investigational, the company shall appoint a panel of one or more qualified individuals to resolve an appeal. The panel must include one or more individuals who: (1) have knowledge of the medical conditions, procedures, or treatment at issue; (2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service; (3) are not involved in the matter giving rise to the appeal or in the initial investigation of the Grievance; and (4) do not have a direct business relationship with the Insured Person or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.

The company will resolve the appeal of a Grievance decision as soon as reasonable possible but not later than 45 days after the appeal is filed.

The company will allow an Insured Person the opportunity to: (1) appear in person before; or (2) if unable to appear in person, to communicate with; the panel appointed.

The company will notify an Insured Person in writing of the resolution of an appeal of a Grievance decision within 5 business days after completing the investigation. The appeal resolution notice will include the following: (1) the decision reached by the company; (2) the reasons, policies, and procedures that are the basis of the decision; (3) notice of the Insured Persons right to further remedies allowed by law, including the right to External Grievance review by an independent review organization; and (4) the department, address, and telephone number through which an Insured Person may contact a qualified representative to obtain more information about the decision or the right to an External Grievance review.

EXTERNAL REVIEW OF A GRIEVANCE

An Insured Person may request an external review regarding: (1) an Adverse Determination of appropriateness; (2) an Adverse Determination of medical necessity; or (3) a determination that a proposed service is experimental or investigational; made by the company, an agent of the company, or the treating health care provider.

The Insured Person, or their representative may file a written request with the company for an External Grievance review within 120 days after the Insured Person is notified of the resolution. An Insured Person may request an expedited external appeal for a Grievance related to an illness, disease, condition, injury, or a disability if the time frame for a standard review would seriously jeopardize the Insured Persons: (1) life or health; or (2) ability to reach and maintain maximum function.

When an external review is requested, the company shall select a different independent review organization on a rotating basis, based on the Indiana Department of Insurance's current IRO rotation list. The chosen independent review organization shall assign a medical review professional who is board certified in the specialty for resolution of an External Grievance. The independent review organization and the medical review professional conducting the external review may not have a material professional, familial, financial or other affiliation with any of the following: (1) the company; (2) any officer, director, or management employee of the company; (3) the health care provider or the health care providers medical group that is proposing the service; (4) the facility at which the service would be provided; (5) the development or manufacture of the principle drug, device, procedure, or other therapy that is proposed by the treating health care provider; or (6) the Insured Person requesting the External Grievance review.

All costs will be paid by the company.

The Insured Person who files an External Grievance shall: (1) not be subject to retaliation for exercising the Insured Persons right to an External Grievance; (2) be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process; (3) be permitted to submit additional information relating to the proposed service throughout the review process; and (4) cooperate with the independent review organization by: (a) providing any requested medical information; or (b) authorizing the release of necessary medical information.

The company shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

The independent review organization shall: (1) for an expedited External Grievance, within 3 business days after the External Grievance is filed; or (2) for a standard appeal, within 15 business days after the appeal is filed; make a determination to uphold or reverse the company's appeal resolution based on information gathered from the Insured Person, their designee, the company, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate. When making the determination, the independent review organization shall apply: (1) standards of decision making that are based on objective clinical evidence; and (2) the terms of the Insured Persons accident and sickness insurance policy. The independent review organization shall notify the company and the Insured Person of the determination: (1) for an expedited External

Grievance within 24 hours after making the determination; and (2) for a standard External Grievance within 72 hours after making the determination. This determination shall be binding on the company.

If at any time during the external review the Insured Person submits information to the company that is relevant to the company's resolution of the Insured Persons appeal of a Grievance decision and was not considered by the company during the appeal of Grievance decision: (1) the company may reconsider the resolution of the appeal; and (2) if the company chooses to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

In the event that the company reconsiders the resolution of the appeal based on such relevant information not previously considered, the company shall notify the Insured Persons of the company's decision upon reconsideration: (1) within 72 hours after the relevant information is submitted for reconsideration related to an illness, disease, condition, injury, or disability that would seriously jeopardize the Insured Persons: (a) life or health; or (b) ability to reach and maintain maximum function; or (2) within 15 days after the information is submitted, for reconsideration not described in (1) above.

If the decision upon reconsideration is reached, in the above paragraph, is adverse to the Insured Person, the Insured Person may request that the independent review organization resume the external review. If the company chooses not to reconsider the resolution of the appeal, the company will forward the submitted information to the independent review organization within 2 business days after the company's receipt of the information.