Policy Title: Complaints and Appeals	Effective Date:	Review Date:
Policy Number: IN GA 1	2.24.17	1/1/20, 1/1/21, 1/1/22, 1/1/23 1/1/24, 1/1/25

Wellfleet Insurance Company
Complaints and Appeals Procedures

Indiana

Policy

Wellfleet Insurance Co., Inc. (WIC) is committed to providing quality health care services.
WIC shall provide and communicate to the insured, or persons authorized to act on behalf of the insured, the means to appeal or grieve Adverse Benefit Determinations rendered by WIC or any external utilization Review Agent, if applicable, acting on behalf of WIC in accordance with the rules of the state of Indiana.

A decision rendered solely on the basis that the health plan does not provide benefits for the health service in question is not subject to the WIC Complaints and Appeals Procedure.

Definitions

Adverse Benefit Determination means a determination by WIC or Our designee Utilization review organization that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet WIC's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigative, including denial of Medically Necessary Prescription Drugs and Durable Medical Equipment and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit; The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by WIC or Our designee Utilization review organization of the members eligibility under the Policy; Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage.

Authorized Representative means A person to whom the member has given express written consent to represent them; person authorized by law to provide substituted consent for the member; A family member of the member or their treating health care professional when the member is unable to provide consent; A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or In the case of an Urgent Care claim, a health care professional with knowledge of the members medical condition.

Concurrent claim means a request for a plan benefit(s) by the member that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

Concurrent review means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Grievance means a written complaint submitted by or on the members behalf regarding the:
1. Availability, delivery or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
2. Claims payment, handling or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between the member and WIC.

Health care professional means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Pre-service claim means the request for a plan benefit(s) by the member prior to a service being rendered and is not considered a concurrent claim.

Post-Service Claim means any claims for a plan benefit(s) that is not a Pre-Service Claim.

Prospective review means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with WIC's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Retrospective review means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Urgent Care request means a request for a health care service or course of Treatment with respect to which the time periods for making a non-urgent care request determination:
1.
a. Could seriously jeopardize the member's life or health or their ability to regain maximum function; or
b. In the opinion of a Physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.
2.
a. Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on WIC's behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
b. Any request that a Physician with knowledge of the member's medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

Utilization review organization means an entity that conducts Utilization review, other than WIC performing utilization review for Our own health benefit plans.

Internal Grievances

If the member is not satisfied and wishes to file a grievance with WIC, they may do so orally or in writing.

- WIC shall acknowledge the grievance within five (5) business days after receipt of grievance.
- Document the substance of the grievance and any actions taken.
- Investigate the substance of the grievance, including any aspects involving clinical care.
- Notify the covered individual of the disposition of the grievance and the right to appeal.
- WIC will resolve grievances as expeditiously as possible, but not more than twenty (20) business days after WIC receives all information reasonably necessary to complete the review.
- If WIC is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the WIC's control, WIC shall:
    - Before the twentieth business day, notify the covered individual in writing of the reason for the delay; and
    - Issue a written decision regarding the grievance within an additional ten (10) business days.
- WIC shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation.
- WIC's grievance resolution notice will include the following:
    - A statement of the decision reached by WIC.
    - A statement of the reasons, policies, and procedures that are the basis of the decision.
    - Notice of the covered individual's right to appeal the decision.
    - The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Internal Appeals

If the member does not agree with WIC's decision and wishes to appeal, they must file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an Urgent Care request) . If the claim involves Urgent Care, the member's appeal may be made orally.

The member should submit all necessary information with their appeal. The member should gather any additional information that is identified in the adverse benefit determination notice as necessary to perfect their claim and any other information that they believe will support their claim.

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
(877) 657-5030

Type of Claim	You must file Your appeal within:	You will be notified of Our determination as soon as possible but no later than:
Pre-Service Claim	180 days following receipt of the Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days following receipt of the Adverse Benefit Determination	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	180 days after receipt of Adverse Benefit Determination Pending the outcome of the appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	15 days of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days following receipt of the Adverse Benefit Determination for Pre-Service or Post-Service Claim	15 days of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post-Service Claim
Concurrent: Involving Urgent Care	180 days following receipt of the Adverse Benefit Determination	72 hours of receipt of appeal
Post-Service Claim	180 days following receipt of the Adverse Benefit Determination	60 days of receipt of appeal

External Reviews

If the member's appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or Treatment and they wish to seek an external review from an Independent Review Organization (IRO), They must file a written request for external review.

They may also seek an external review by an IRO for a denial of an Urgent Care request based on medical judgement provided that (1) They have also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an Urgent Care appeal will seriously jeopardize their life or health or would seriously jeopardize their ability to regain maximum function.

They may also seek an external review for a rescission of coverage.

Standard External Review

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, the member may file a request for an external review with WIC.

The member must file their written request for an external review with WIC within 4 months of the date the member received the applicable denial.

Within 5 business days of receiving the member's request for an external review, WIC will complete a preliminary review of the request to determine whether the member was covered under the Policy at

the time the expense was incurred and whether the member has exhausted the Internal Appeal process where required.

In most cases, the member should complete WIC's Internal Appeals process before they:

- File a complaint or appeal with the Indiana Department of Insurance;
- File a request for an External Review;
- Pursue arbitration, litigation or other type of administrative proceedings.

However, in some cases, the member does not have to exhaust the Internal Appeal process before they move on to an External Review. These situations are:

- WIC waives the Internal Appeal process;
- The member has an Urgent Care situation or a claim that involves ongoing treatment. In these situations, the member may have their claim go through the External Review at the same time as the Internal Appeal process; and
- WIC did not follow all of the State or Federal claim determination and appeal requirements. However, the member will not be able to proceed directly to an External Review if:
    - The rule violation was minor and not likely to influence a decision or harm the member;
    - The violation was for a good cause or a matter beyond Our control;
    - The violation was part of an ongoing good faith exchange of information between the member and Us.

Within 1 business day of making a determination, the member will be notified if the external review request is denied and they will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event the member's request is denied due to lack of information or materials, they must perfect their claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that the member request for external review was denied.

If initially eligible for an external review, WIC will assign the request to an IRO. The IRO will make a determination and provide the member and Us with notice of its determination within 45 days of receiving the review request.

External Review of Denial of Experimental or Investigative Treatment

If, due to the members medical condition, the time frame for completion of the standard external review process would seriously jeopardize the member's life or health or the member's ability to regain maximum function, the member may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, WIC will assign the request to an IRO and the IRO will complete the review as expeditiously as the member's medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to the member orally, a written or electronic notification will be sent to the member no later than 48 hours after the oral notification.

Important Information

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior level of appeal will not be involved in the appeal).

- The claims reviewer will review relevant information that the member submits even if it is new information. In addition, the member has the right to request documents or other records relevant to their claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.
- The member may review the claim file and present evidence and testimony at each state of the appeals process.
- The member may request, free of charge, any new or additional evidence considered, relied upon, or generated by WIC in connection with their claim.
- If a decision is made based on new or additional rationale, the member will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If the member wishes to submit relevant documentation to be considered in reviewing their claim for appeal, it must be submitted with their claim and/or appeal.
- The member should exhaust these appeals procedures before filing a complaint or appeal with the Indiana Department of Insurance.
- The member should raise all issues that they wish to appeal during the Internal Appeal process and during the External Review.

Contact Information

If the member has any questions or concerns, they can contact WIC at:
WIC Insurance Company
Attention: Appeals Unit
WIC Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

The member may contact the Indiana Department of Insurance for assistance at any time.
Address:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline (800) 622-4461
Complaints can be filed electronically at www.in.gov/idoi

Reviewer: **Printed Name:** John Florek **Title:** Appeals Manager	**Signature:** _____ **Date:** January 3, 2020