

GRIEVANCE AND APPEALS

A “**Grievance**” means any dissatisfaction expressed to Us by You or Your authorized representative in reference to an adverse decision regarding:

- A determination that a service or proposed service is not appropriate or Medically Necessary;
- A determination that a service or proposed service is Experimental or Investigational;
- The availability of participating providers;
- The handling or payment of claims for health care services;
- Matters pertaining to the contractual relationship between You and Us or the Policyholder and Us;
or
- Our decision to rescind coverage.

GRIEVANCE PROCEDURES

If You have received an adverse decision by Us, You may file a Grievance. We will review Your Grievance in accordance with the following procedures. If You need assistance or require further information, You may call 1-800-371-9622 and speak to a qualified representative who is knowledgeable about Our Grievance and Appeal procedures.

You must file a Grievance within 180 days after You receive notice of Our adverse decision. You may file Your Grievance by calling [1-800-371-9622] or by mailing a written Grievance to:

MAIL: Pekin Insurance
Health Claim Appeals
2505 Court Street
Pekin, Illinois 61558-0001

FAX: (309)346-8265
EMAIL: HealthClaimAppeal@pekininsurance.com

You have the option of presenting evidence and testimony to Us, by phone or in person at a location of Our choice. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after You receive notice of an adverse decision or at any time during the Grievance process.

We will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents obtained during the Grievance process without regard to whether such information was considered in the initial determination. No deference will be given to the initial adverse decision. Such new or additional evidence or rationale and information will be provided to You or Your authorized representative sufficiently in advance of the date a final decision is made in order to give You a chance to respond. The Grievance process will be conducted by individuals associated with Us and/or by external advisors, but who were not involved in making the initial adverse decision.

EXPEDITED GRIEVANCES

If Your Grievance relates to an urgent service or proposed service, including, but not limited to, procedures or Treatments ordered by a health care provider, for which the denial could significantly increase the risk to the Insured’s health, then You may be entitled to a Grievance review on an expedited basis. Before authorization of benefits for an ongoing course of Treatment is terminated or reduced, We will provide You with notice and an opportunity to appeal. For the ongoing course of Treatment, coverage will continue during the Grievance process.

Upon receipt of an urgent service or proposed service Grievance, We will notify the party filing the Grievance, as soon as possible, but no more than 24 hours after submission of the Grievance, if additional information is needed. Additional information must be submitted within 24 hours of the request. We shall render a determination within 24 hours after receiving the requested information.

OTHER GRIEVANCES

Upon receipt of a non-urgent service or proposed service Grievance, an acknowledgement of receipt will be sent within 5 business days. We shall render a determination of the Grievance as expeditiously as possible, but no more than 20 business days after We have received all information necessary.

If additional information is needed, We will notify You in writing of a 10 business day extension. This notice of extension will be sent to You before the end of the 20 day period. The extension may occur when information is needed and requested from either You or Your health care provider. In the event of an extension, We will resolve the Grievance within 30 business days from the date we received the Grievance. If the requested information is not received, We will make a determination based on the information within Our possession.

Once We have made a determination regarding the Grievance, We will notify You in writing within 5 business days.

APPEALS

An “**Appeal**” is a formal request by You or Your authorized representative for reconsideration of a decision not resolved to Your satisfaction under the Grievance level.

If You are not satisfied with the determination of Your Grievance, You or Your authorized representative may Appeal Our decision by notifying Us at the above listed phone number or address. We will acknowledge receipt of Your Appeal within 5 business days. A decision on Appeal will be made within 45 business days after the Appeal is filed. We will notify You in writing within 5 business days following the Appeal decision. If You are appealing a Grievance decision for a service or proposed service that was not found to be appropriate or Medically Necessary, or a service or proposed service which was determined to be Experimental or Investigational, You may have the right to an independent physician review.

EXPEDITED APPEALS

There may be situations where the normal Appeal process may not apply. An expedited Appeal can be implemented for urgent situations such that Your health may be in serious jeopardy, or in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision on the Appeal. Expedited Appeals will be resolved within 48 hours after receipt of the Appeal. The Appeal must include adequate information for Us to make a determination upon review.

NOTICE OF GRIEVANCE AND APPEAL DETERMINATION

We will notify the party filing the Grievance or Appeal and any applicable health care provider orally and/or by written notice.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions, on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and information about how to obtain diagnosis, Treatment and denial codes with their meanings;
4. An explanation of Our external review processes (and how to initiate an external review);
5. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;

7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and
9. A description of the standard that was used in making an adverse decision and a discussion of the decision.

If Our decision is to continue to uphold Our denial or partial denial or You do not receive a timely decision, You may be able to request an external review by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the External Grievance section below.

EXTERNAL GRIEVANCE

An “**External Grievance**” is Your right to request an external review of an Appeal decision that is not acceptable to You. An External Grievance is conducted by an Independent Review Organization (IRO). You may be eligible to request an External Grievance if Your continued Grievance is regarding:

- An adverse determination of appropriateness; or
- An adverse determination of Medical Necessity; or
- A determination that a service or proposed service is Experimental or Investigational; or
- Our decision to rescind coverage.

You or Your authorized representative must make a request for an External Grievance within 4 months of receiving Our decision on Appeal. After receiving Your request for an External Grievance, we will promptly forward the Grievance, along with all relevant information to an approved IRO. The IRO will make a determination to uphold or reverse our decision within 15 business days of the filed request. The IRO will notify You and Us of its determination within 72 hours for services or proposed services which are non-urgent.

The IRO will be selected from the IRO Rotation Assignment List published on the Indiana Department of Insurance website. We will sequentially use the IROs without repeating until entire list has been selected.

EXPEDITED EXTERNAL GRIEVANCE

There may be situations where the normal External Grievance process may not apply. An expedited External Grievance can be implemented for urgent situations in which Your health may be in serious jeopardy, or in the opinion of Your physician, You may experience pain that cannot be adequately controlled while You wait for a decision. For an expedited External Grievance, an IRO will render a decision within 72 hours after filing and will notify You and Us of its determination within 24 hours.

Upon receipt of a notice of an IRO’s decision to reverse Our adverse decision, We shall immediately approve the coverage that was the subject of the determination, except for those services which may be specifically excluded under the Policy.

An External Grievance decision is binding on Us. You and Your authorized representative may not file a subsequent request for external review involving the same adverse decision for which You have already received an External Grievance decision.

RECONSIDERATION OF ADVERSE DECISION

If at any time during the External Grievance process You or Your authorized representative submit additional information which may result in Us reconsidering Our adverse decision, We will request that the IRO cease the External Grievance review until Our reconsideration is completed. For a non-urgent service or proposed service We will complete Our reconsideration within 15 days after the information is

submitted. For an urgent service or proposed services We will complete Our reconsideration within 72 hours after the information is submitted.

If Our reconsideration continues to be adverse, You may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.