

## NOTICE OF GRIEVANCE PROCEDURES FOR INDIANA RESIDENTS

If You have questions about any decisions related to Your coverage with Trustmark Insurance Company (Trustmark), You may call Us and a Customer Service Representative will assist You.

**LEVEL 1:** Within 180 days from receipt of a claim decision, You, or Your personal representative may submit an oral or written request for a formal grievance review, if You have a complaint about any of the following:

- Trustmark's decisions, policies, or actions related to coverage of health care services;
- Claims payment or handling;
- The contractual relationship between a Covered Person and Trustmark;
- The outcome of an appeal on a denial of certification of an admission or continued stay;
- The availability of participating providers;
- The determination that a proposed service is not appropriate or medically necessary, or that a proposed service is experimental or investigational;
- Rescissions.

If You feel Our determination on any of the above did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may file a grievance.

- We will, within 5 business days after receiving Your grievance, provide oral or written acknowledgment of the request.
- A decision will be made within 20 business days after receiving all the information necessary to complete the review.
- You will be informed of the grievance resolution, and Your right to appeal the decision, within five (5) business days after the investigation is completed.
- If We are unable to make a decision within that time frame due to circumstances beyond Our control, We will notify You, in writing and before 20<sup>th</sup> business day, of the reason for delay. You will then receive a written decision regarding the grievance and Your right to appeal the decision within additional 10 business days.

**Written requests should contain the issues and comments which are pertinent and should be sent or faxed to:**

**Trustmark Insurance Company  
Grievance Review Board  
8324 South Avenue  
Boardman, OH 44512  
Fax (330) 965-7599**

Or You may call Trustmark Insurance Company at 1-800-366-6663 for information or to make a formal grievance request.

**LEVEL 2-GRIEVANCE APPEAL:** If You feel Our determination did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may, within 60 days from receipt of the initial grievance review decision, request another appeal.

- We will, within 5 business days after receiving Your Grievance Appeal request, provide oral or written acknowledgment of the appeal. At that time We will inform You of the date on which a panel will meet to discuss Your appeal and of Your right to appear in person, or, if You are unable to appear, how to otherwise communicate with the panel, for Grievance Appeals regarding medical necessity or experimental or investigational procedures.
- A decision will be made within 45 days after receiving Your Grievance Appeal request.
- You will be informed of the Grievance Appeal resolution within five (5) business days after the investigation is completed.
- If We deny Your claim for medical services at the Grievance Appeal level, We will advise You that Our decision is a Final Adverse Decision and advise You of Your right to request an External Review by an independent review organization, or to obtain additional information, at the address or phone number listed above.

**LEVEL 3-EXTERNAL REVIEW:** If You feel that Our determination of a Final Adverse Decision did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may file a written request for an External Grievance Review not more than 120 days after You are notified of the Grievance Appeal determination concerning any of the following:

- An adverse determination of appropriateness,
- An adverse determination of medical necessity,
- Rescissions, or
- A determination that a proposed service is experimental or investigational, made by Us or one of Our agents regarding a service proposed by Your treating health care provider.

We will provide an expedited External Grievance Review for a grievance related to an illness, disease, condition, injury or a disability if the time frame for a standard review would seriously jeopardize Your life, health or Your ability to reach and maintain maximum function. We will provide a Standard Grievance Review for all other grievances.

- A decision will be made within 72 hours after an Expedited External Grievance is filed and You will be notified within 24 hours after the determination is made.
- A decision will be made within 15 business days after a Standard External Grievance is filed and You will be notified within 72 hours after the determination is made.

You will not be required to pay any costs associated with the services of an independent review organization. We are responsible for all associated costs. We will select the independent review organization from the list on the Indiana Department of Insurance website (IRO Rotation Assignments List). The selection process will be done sequentially without repeating until the entire list has been selected.

You may only file one external grievance review request per Grievance Appeal resolution. In addition, if You have the right to an external review by Medicare, You may not request an External Grievance Review under this process.

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, IN 46204  
Consumer Hotline: (800) 622-4461  
[www.in.gov/idoi](http://www.in.gov/idoi)

## NOTICE OF YOUR CLAIM AND APPEAL RIGHTS

### How We Pay Claims

Upon receipt of a claim, We will evaluate if benefits are available under this Certificate. All claims, electronic and paper, will be reviewed and processed in the order they are received in Our office without preference and in accordance with state and federal legislative requirements [and according to network contract allowance].

The time periods for processing a claim and providing additional information vary depending on the type of claim at issue as described below.

### Post-Service Claims

Post-service claims are those filed for payment of benefits after medical care has been received.

We will notify the Covered Person, within 30 days after receiving your electronic claim or within 45 days after receiving your written claim that the claim has been received and what your benefits are determined to be.

If more than 30 days for an electronic claim or 45 days for a written claim are needed to determine benefits due to reasons beyond Our control, We will notify the Covered Person within that 30 day period that more time is needed to determine benefits. But, in any case, We may not take more than 45 days to determine your benefits.

If the Covered Person does not submit all the necessary information, We will provide notice explaining what information is needed. The Covered Person has 45 days to provide the information needed to process the claim. The time period during which We are waiting for receipt of the necessary information does not count toward the time frame in which We must make a benefit determination. If the Covered Person does not provide the requested information within the 45 day period, the claim will be denied. The Covered Person may submit such claim for reconsideration, with the requested information, within the timeframe specified below in *How To Appeal a Claim Decision*.

### Pre-service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care.

We will notify the Covered Person, within 15 days after receiving a claim, that the claim has been received and what the benefits are determined to be.

If We need more than 15 days to determine benefits, due to reasons beyond Our control, We will notify the Covered Person within that 15 day period that more time is needed. But, in any case, We may not take more than 30 days to determine benefits.

If the Covered Person does not submit all the necessary information, We will provide notice within 5 days explaining the additional information needed. The Covered Person has 45 days to provide the information necessary to process the claim. The time period during which We are waiting for receipt of the necessary information does not count toward the time frame in which We must make a benefit decision. If the Covered Person does not provide the requested information within the 45 day period, the claim will be denied. The Covered Person may submit such claim for reconsideration, with the requested information, within the timeframe specified below in *How To Appeal a Claim Decision*.

### Urgent Claims that Require Immediate Attention

Urgent claims are those claims that require notification or approval prior to receiving medical care, where delay in treatment could seriously jeopardize the Covered Person's life or health, or the ability to regain maximum function or, in the opinion of a Doctor with knowledge of the Covered Person's medical condition, could cause severe pain. In these situations:

We must notify the Covered Person, within 72 hours after receiving a claim that the request has been received and what benefits are determined to be.

If the Covered Person does not submit all the necessary information, We will notify the Covered Person by fax or telephone within 72 hours of the additional information needed. The Covered Person will have 48 hours to provide Us with the information necessary to process the claim. The Covered Person will be notified of a benefit decision no later than 48 hours after Our receipt of the requested information. If the requested information is not received within such 48 hours, a decision will be made based on the information available.

### **Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend the treatment is an urgent claim as defined above, We will make a determination within 24 hours of the request, provided the request is made at least 24 hours prior to the end of the approved treatment. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend treatment is a non-urgent circumstance, the request will be considered according to post-service or pre-service timeframes described above, whichever applies.

### **Notice of Benefit Decision**

If the claim is denied in whole or in part, a notice of this denial will include identification of the claim involved, the reason for the decision, the Certificate provisions relied upon in making the decision, an explanation of the Covered Person's rights to appeal and the process for making an appeal, the availability of and contact information for Our office and other agencies and offices available to assist with the appeals process and any additional information required by law.

### **What to Do if You Disagree With Our Decision**

This section outlines the Covered Person's rights to file an appeal.

### **How to Appeal a Claim Decision – Internal Appeal Process**

The Covered Person may appeal a claim decision. The Covered Person's appeal rights will be forfeited if the Covered Person fails to submit the appeal to Us, verbally or in writing, to the address identified below, within 180 days from receipt of the claim decision.

The Covered Person may submit a verbal or written request for a formal grievance review, if there is a complaint about any of the following:

- 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 a Covered Person and Trustmark; or a group policyholder and Trustmark; or
- Rescissions

All Covered Persons who are dissatisfied with a first level appeal review will have the right to request a second level appeal review. The second level appeal request must be submitted to Us verbally or in writing, within 60 days from receipt of the first level appeal decision. All appeals will be reviewed by someone with the appropriate expertise and who was not involved with the original decision.

We will provide the Covered Person with a full and fair review of the claim appeal. If We uphold a claim decision on the second level of appeal, We will provide the Covered Person with any new or additional evidence that was considered, relied upon, or generated by Us in connection with the claim review in advance of the date on which the notice of a final internal benefit determination is provided.

The verbal or written appeal should include the Covered Person's name and identification number from the identification card, the basis for the appeal and any supporting documentation. If the appeal relates to a claim payment decision, the verbal or written appeal should also include the date(s) of medical service(s) and the applicable health care provider's name.

Faxed or written appeals must be sent to:

Trustmark Insurance Company  
Grievance Review  
8324 South Avenue  
Boardman, OH 44512  
Phone (800) 396-2960  
Fax (330) 965-7599

### **Timeframes for Internal Appeals**

We will, within 5 business days after receiving the Covered Person's appeal, provide verbal or written acknowledgement of the request. The Covered Person will be provided notification of Our decision on the appeal as follows:

- Urgent care claims: We will notify the Covered Person of Our decision within 72 hours from Our receipt of the appeal. Depending on the nature of the review, the Covered Person may have the right to request an expedited external review. Refer to *Request For Expedited External Review* below.
- Pre-service claims: For both the first and second level of appeal, We will notify the Covered Person, verbally or in writing, of Our decision within 15 days from Our receipt of the appeal.
- Post-service claims: For the first level of appeal, We will notify the Covered Person, verbally or in writing, of Our decision within 20 days from Our receipt of the appeal. For the second level of appeal, We will notify the Covered Person verbally or in writing, of Our decision within 30 days from Our receipt of the appeal.

For the first level of appeal for post-service claims, if we are unable to make a decision within these time frame due to circumstances beyond our control, we will notify you, verbally or in writing and before 20<sup>th</sup> business day, of the reason for delay. You will then receive a verbal or written decision regarding the grievance and your right to appeal the decision within additional 10 business days.

For the second level appeal, at the time of providing the acknowledgement of the request We will inform the Covered Person of the date on which a panel will meet to discuss the Covered Person's appeal and of the right to appear in person, or, if the Covered Person is unable to appear, how to otherwise communicate with the panel.

The Covered Person may request an expedited internal review following receipt of an adverse claim determination of the medical necessity and appropriateness of health care services provided or proposed to be provided for emergency or life threatening situations. In the event of an expedited internal review, a determination will be made as expeditiously as possible after the appeal is initiated and all information necessary to complete the appeal is received by Us.

If the Covered Person fails to submit the written appeal to the correct address or fax number or call the incorrect phone number, We reserve the right to deny the request and will inform the Covered Person of such denial. We may also choose to process the request, however the timeframe for processing the appeal will not begin to run until the correspondence is received by the Grievance Review area of Our office.

Once the Covered Person has exhausted both the first and second level appeals, the Covered Person will be informed of the right to request an external review by an independent review organization.

### **How to Appeal a Decision – External Review Process**

The notice of a final internal adverse benefit determination will include detailed information about a Covered Person's right to request an external review and the process for making such request.

The Covered Person will have 4 months after the date of the final internal adverse benefit determination to request an external review concerning any of the following:

- An adverse determination of appropriateness
- An adverse determination of medical necessity
- A determination that a proposed service is experimental or investigational;
- Rescissions

In the event of an external review, a determination will be made within 15 business days after an external review is filed and the Covered Person will be notified with 72 hours after the determination is made.

### **Request For Expedited External Review**

The Covered Person may request an expedited external review at any time following receipt of an adverse claim determination (even if the person has not exhausted the internal appeal process), if such determination involves a medical condition for which the timeframe to complete an internal appeal or the timeframe to complete a standard external review seriously jeopardize the Covered Person's life, health, or ability to regain maximum function. In the event of an expedited external review, a determination will be made within 72 hours after the expedited external review is filed, and the Covered Person will be notified within 24 hours after the determination is made.

### **Preliminary Review**

Within 5 business days of receipt of the request for an external review (or immediately in the case of a request for an expedited external review), We will determine whether:

- a. The Covered Person had coverage at the time the service was provided or requested;
- b. External review is available based on the reason for the adverse benefit determination;
- c. The Covered Person exhausted the internal appeals process, if required; and
- d. The Covered Person provided all information needed to process the external review.

Within 1 business day of the preliminary review determination (or immediately in the case of a request for an expedited external review), We will send written notice to the Covered Person (or their authorized representative) as to whether the request has been accepted. If the Covered Person is not eligible for external review, the written notice will explain the reason for the ineligibility and provide contact information for the Employee Benefits Security Administration. If the request for external review is not complete, the written notice will describe the information or materials needed and will give the Covered Person until the end of the 4 month period or 48 hours, whichever is later, to provide such information or materials.

### **Independent Review Organization**

If the independent review organization reverses Our decision, We will pay the claim or otherwise provide coverage consistent with the independent review organization's determination. The independent review organization's decision is binding on Us.

You will not be required to pay any costs associated with the service of an independent review organization. We are responsible for all associated costs. We will select the independent review organization from the list on the Indiana Department of Insurance website (IRO Rotation Assignment List). The selection process will be done sequentially without repeating until the entire list has been selected.

## NOTICE

As a Trustmark Insurance Company certificate holder, your satisfaction is very important to Us. Should you have a valid claim, We fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied. . .

Should you feel you are not being treated fairly; We want you to know you may contact the Indiana Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

Public Information/Market Conduct  
Indiana Department of Insurance  
311 West Washington Street, Suite 300  
Indianapolis, IN 46204-2787

Consumer Hotline: 1-800-622-4461  
In the Indianapolis Area: 1-317-232-2395