

For purposes of this notice, “Adverse Benefit Determination” means a decision by us that an admission, continued stay, or other health care service has been reviewed and based upon the information provided, does not meet our requirements for a covered charge, appropriateness, health care setting, level of care, or effectiveness and is not payable (in whole or in part). Coverage is therefore denied, reduced or rescinded.

For the purpose of the right to file a grievance, “Grievance” means any dissatisfaction expressed orally or in writing by or on your behalf 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 of payment of claims for health care services; matters pertaining to the contractual relationship between you and us or your employer and us; or our decision to rescind your coverage; and for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Payment, Denial, and Review

We will pay or deny a claim submitted by a provider within 30 calendar days of receipt of an electronic claim or within 45 calendar days of receipt of a claim filed by paper. If a claim cannot be processed due to incomplete information, we will send a written explanation describing the information necessary to establish receipt of claim prior to the expiration of the 30 calendar days for electronic claims or 45 calendar days for claims filed by paper. The claimant is then allowed up to 45 calendar days to provide all additional information requested. We will pay or deny the claim within 30 calendar days for claims filed electronically and 45 calendar days for claims filed by paper of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided, we receive complete and proper proof of loss. If a claim is not payable or cannot be processed, we will submit a detailed explanation of the basis for the denial.

For purpose of this notice, “claimant” means Member or Dependent.

Complaint and Grievance Procedures

First-Level Appeal Review

You or a designated patient representative acting on your behalf may request an appeal of an Adverse Benefit Determination or file a Grievance by oral or written request to us within 180 calendar days of receipt of the notice of Adverse Benefit Determination. The written request should be sent to the local service center (the address is shown on your ID card) or to the toll-free number provided. We will acknowledge the Grievance, either orally or in Writing, within five (5) business days after receipt of the Grievance.

We will make a full and fair review of the claim. We may require additional information to make the review. We will notify you in writing of the appeal decision within 20 business days of receiving the appeal request for post-service claims and 15 calendar days for pre-service claims. If the appeal is regarding the availability of participating providers, the handling or payment of claims for health care services, or matters pertaining to the contractual relationship between you and us, or the policyholder and us, we will notify you in writing of the appeal decision within 20 business days of receiving the appeal request. We will send a written notice of our decision within five business days after our review is completed. This notice will include:

- a statement of the decision reached by us;
- a statement of the reasons, policies, and procedures that are the basis for our decision;
- notice of your right to appeal the decision; and
- the department, address, and telephone number through which you may contact us to obtain additional information about the decision or the right to appeal.

If a decision is unable to be reached within the twenty-day period due to circumstances beyond our control, we will notify you before the 20th day. We will send a written decision within an additional ten business days.

Second-Level Appeal Review

If the Adverse Benefit Determination or Grievance decision is affirmed on the first-level appeal review resulting in a final internal Adverse Benefit Determination or Grievance decision, you or a designated patient representative acting on your behalf may request a second-level appeal review. The second-level appeal review must be requested in writing within 60 calendar days of receipt of the final internal Adverse Benefit Determination or Grievance decision. The written request should be sent to the local service center (the address is shown on your ID card) or to the toll-free number provided. We will acknowledge the request for a second-level appeal, either orally or in Writing, within five (5) business days after receipt of the request for a Second-Level Appeal. We will make a full and fair review of the claim. You may submit written comments, documents, records and other information relating to the claim for benefits.

If the appeal is regarding a determination that a service or proposed service is not appropriate or medically necessary or a determination that a service or proposed service is experimental or investigational, We will appoint a panel of one or more qualified individuals to resolve the appeal. You may appeal in person, or communicate by telephone, with the panel. The panel will make a decision as expeditiously as possible, reflecting the clinical urgency of the situation.

We will notify you in writing of the appeal decision within 30 calendar days of receiving the appeal request for post-service claims and 15 calendar days for pre-service claims. We will send a written notice of our decision within five business days after our review is completed. This notice will include:

- a statement of the decision reached by us;
- a statement of the reasons, policies, and procedures that are the basis for our decision;
- notice of your right to further remedies allowed by law, including the right to External Review by an independent review organization; and
- the department, address, and telephone number through which you may contact us to obtain additional information about the decision or the right to an External Review.

If the appeal is regarding the availability of participating providers, the handling or payment of claims for health care services, or matters pertaining to the contractual relationship between you and us, or the policyholder and us, we will resolve the Grievance as expeditiously as possible, reflecting the clinical urgency of the situation, but no later than 30 calendar days after the appeal is filed. We will notify you in writing of the decision within five business days. This notice will include:

- a statement of the decision reached by us;
- a statement of the reasons, policies, and procedures that are the basis for our decision;
- notice of your right to further remedies allowed by law; and
- the department, address, and telephone number through which you may contact us to obtain additional information about the decision.

Expedited Appeal Review

An expedited appeal review will be made available in a situation where the timeframe of the first-level appeal review and second-level appeal review would seriously jeopardize your life or health, or the ability to regain maximum function.

You or a designated patient representative acting on your behalf may initiate an expedited appeal review, either orally or in writing. In an expedited appeal review, all necessary information, including our decision, will be transmitted between us and you or the provider acting on your behalf by telephone, facsimile or other available similarly expeditious method.

We will make a decision and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours after receipt of the request for the expedited appeal review.

We will not discriminate against providers based on their actions taken on your behalf in making an appeal.

For assistance with respect to any claim, Grievance, or appeal at any time, you have the right to contact the Indiana Department of Insurance Consumer Hotline at 1-800-622-4461 or write to:

Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

External Review**Right to Request an External Review**

You or a designated representative or provider acting on your behalf have the right to an external review regarding an Adverse Benefit Determination of appropriateness; an Adverse Benefit Determination of medical necessity; a determination that a proposed service is experimental or investigational; or a decision to rescind your coverage regarding a service proposed by the treating health care provider.

You or a designated representative or provider acting on your behalf may file an external appeal in writing within 120 days after you are notified of the resolution of the appeal of a Grievance decision that applies to appropriateness, medical necessity, or that a proposed service is experimental or investigational.

Expedited External Review

An expedited external review may be requested if you have an illness, disease, condition, injury, or a disability if the time frame for a standard review would seriously jeopardize your life or health or ability to reach and maintain maximum function.

External Appeal Review

For a standard appeal, a determination will be made by the independent review organization within fifteen (15) business days after the appeal is filed. Notice will be given to you within seventy-two (72) hours after making the determination.

For an expedited appeal, a determination will be made by the independent review organization within seventy-two (72) hours after the appeal is filed. Notification will be given to you within twenty-four (24) hours after making the determination.

You may submit additional information to us that is relevant to the appeal of a Grievance decision at any time during the external review. The independent review organization will cease the external review process until our reconsideration is complete. We will make a determination on the additional information within fifteen (15) days after the information is submitted for a standard appeal or within seventy-two (72) hours for an expedited appeal. If our determination is adverse to you, you may request that the independent review organization resume the external review.

We will pay for all costs of the external review. We will select an independent review entity 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. The determination by the independent review organization is binding on us.