

## **DISPUTE, GRIEVANCE AND APPEAL PROCEDURE**

PO Box 4884, HOUSTON, TX 77210-4884 OR TOLL FREE 800-552-7879

### **First level review of adverse determination.**

You may file a grievance or appeal with Us within one hundred and eighty (180) days after the date of receipt of a notice of an adverse determination by requesting a first level review of the adverse determination. The grievance or appeal may be filed to Our Home Office at the address above to the Attention of the Appeals Department or You may contact Us at the toll free number listed above and lodge a verbal request for appeal. Normally You do not have the right to attend, or to have a representative in attendance at the first level review; however You do have the following rights:

- (i) You may submit written comments, documents, records and other material relating to the request for benefits for Us to consider when conducting the review; and
- (ii) You may receive from Us, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

For the purposes of a review request, a document, record or other information shall be considered relevant to an aggrieved person's request for benefits if the document, record or other information:

- (i) Was relied upon in making the benefit determination;
- (ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;
- (iii) Demonstrates that, in making the benefit determination, We or Our designated representatives applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
- (iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied healthcare service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

We will make the above information known to You within five (5) business days after the date of receipt of the grievance if requested to do so; provided, that the request was made to the Attention of the Appeals Department or You may contact Us at the toll free number listed above and lodge a verbal request for appeal. The time period shall begin on the date the grievance requesting the first level review is received by Us in accordance with Our procedures as referenced herein, without regard to whether all of the information necessary to make the determination accompanies the filing. We will notify and issue a decision, in writing or electronically, to You within the timeframes of either:

- (i) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, We will notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of Our receipt of the grievance requesting the first level review made; or
- (ii) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, We will notify and issue a decision within a reasonable period of time, but no later than forty-five (45) days after the date of Our receipt of the grievance requesting the first level review made.

Our decision will be set forth in in clear and understandable language and will include:

- (i) The titles and qualifying credentials of the person or persons participating and reviewing in the first level review;
- (ii) A statement of each reviewer's understanding of the grievance;
- (iii) Each reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail for You to respond further to Our position;
- (iv) A reference to the evidence or documentation used as the basis for the decision;
- (v) For a first level review decision issued involving an adverse determination: (1) The specific reason or reasons for the adverse determination; (2) A reference to the specific plan provisions on which the determination is based; (3) A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in the second paragraph, to the covered person's benefit request; (4) If We relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse

determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to You upon request and the date such policy was effective; (5) If the adverse determination is based on medical necessity, either an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that an explanation will be provided to You, free of charge upon request; and (6) If applicable, instructions for requesting a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a written statement of the criteria for the determination. If applicable, a statement indicating: (a) A description of the process to obtain a second level review of the first level review's decision involving an adverse determination, if You wish to request a second level review; (b) The written procedures governing the second level review, including any required timeframe for the review; and (c) A description of the procedures for obtaining an external review of the adverse determination if You decide not to file for a second review of the first level review's decision involving an adverse determination.

- (vi) Notice of your right to further remedies allowed by law, including the right to external grievance review by an independent review organization.
- (vii) The name and address of the Indiana Department of Insurance.
- (viii) The telephone number at which you may contact a representative to obtain more information about our decision and/or the right to an external grievance review.

### **Second level review of adverse determination**

We have established a second level review process so that if You are dissatisfied with the first level review decision You have the option of requesting a second level review. We will provide You with notice, as appropriate, of the option to file a request with Us for a second level review of the first level review's decision. Upon receipt of a request for a second level review, We will send notice within five (5) business days to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

- (i) Request, within the timeframe specified, the opportunity to appear in person before a review panel of Our designated representatives;
- (ii) Receive from Us, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;
- (iii) Present the covered person's case to the review panel;
- (iv) Submit written comments, documents, records and other material relating to the request for benefits to the review panel for consideration when conducting the second level review both before and, if applicable, during the second level review;
- (v) If applicable, ask questions of any of Our representatives on the review panel; provided, such questions are governed and relevant to the subject matter of the second level review; and
- (vi) Be assisted or represented by an individual of the covered person's choice, at the expense of such covered person.

A covered person or covered person's authorized representative wishing to request to appear in person before the review panel of Our designated representatives shall make request to Us within ten (10) business days after the date of receipt of the notice sent to the Attention of the Appeals Department or You may contact Us at the toll free number listed above. The covered person's right to a fair review shall not be made conditional on the covered person or the covered person's authorized representative's appearance at the second level review.

Upon receipt of a request for a second level review, We will send notice within five (5) business days to the healthcare provider of the healthcare provider's right to:

- (i) Receive from Us, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the aggrieved person's request for benefits;
- (ii) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the second level review; and
- (iii) If applicable, ask questions of any representative of Our's on the review panel; provided, such questions are governed and relevant to the subject matter of the second level review.

With respect to a second level review of a first level review decision We will appoint a review panel to review the request. In conducting the review, the review panel shall take into consideration all comments, documents, records

and other information regarding the request for benefits submitted by the aggrieved person, without regard to whether the information was submitted or considered in reaching the first level review's decision. The review panel shall have the legal authority to bind Us to the review panel's decision. A majority of the review panel shall be comprised of individuals who were not involved in the first level review decision. An individual who was involved with the first level review decision may be a member of the review panel or appear before the review panel to present information or answer questions.

We will ensure that the individuals conducting the second level review of the first level review decision have appropriate expertise or have access to appropriate expertise that consists of similar knowledge and training or specialty that typically is involved in managing the medical condition, procedure or treatment that is the subject of the grievance under second level review. No member of the review panel shall have a direct financial interest in the outcome of the second level review.

The procedures for conducting the second level review shall include the following provisions:

- (i) The review panel shall schedule and hold the second level review within forty-five (45) days after the date of receipt of the request for a second level review. The aggrieved person shall be notified in writing at least fifteen (15) business days in advance of the date of the second level review. We will not unreasonably deny a request for postponement of the second level review made by the aggrieved person;
- (ii) The second level review shall be held during regular business hours at a location that meets the guidelines established by the Americans with Disabilities Act, compiled in 42 U.S.C. § 1201 et seq., to the aggrieved person;
- (iii) In cases where an in-person second level review is not practical for geographic reasons, or any other reason, We will offer the aggrieved person the opportunity to communicate with the review panel, at Our sole expense, by conference call or other appropriate technology as determined Us;
- (iv) The review panel shall provide the aggrieved person notice of the right to have an attorney present at the second level review; and
- (v) The review panel shall issue a written or electronic decision, as provided below, to the aggrieved person within five (5) business days of completing the second level review meeting.

A decision issued shall include the:

- (i) Titles and qualifying credentials of the reviewers on the review panel;
- (ii) Statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
- (iii) Rationale for the review panel's decision;
- (iv) Reference to evidence or documentation considered by the review panel in rendering its decision; and
- (v) In cases concerning a grievance involving an adverse determination: (1) Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and (2) If applicable, a statement describing the procedures for obtaining an external review of the adverse determination.
- (vi) Notice of your right to further remedies allowed by law, including the right to external grievance review by an independent review organization.
- (vii) The name and address of the Indiana Department of Insurance.
- (viii) The telephone number at which you may contact a representative to obtain more information about our decision and/or the right to an external grievance review.

### **Expedited Review**

We will provide expedited review of a grievance involving an adverse determination with respect to concurrent review of urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility. We will allow an aggrieved person to request an expedited review orally, in writing or electronically.

We will appoint an appropriate clinical peer, or peers as would typically manage the case being reviewed, to review the adverse determination. The clinical peer or peers shall not have been involved in rendering the initial adverse determination. We will provide or transmit all necessary documents and information considered when making the adverse determination to the aggrieved person participating in the expedited review process electronically or by telephone, facsimile or any other expeditious method available.

An expedited review decision shall be rendered and the aggrieved person shall be notified of the decision as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review of an urgent care request, the service shall be continued until the covered person or covered person's authorized representative has been notified of the determination or until the health care provider determines that the urgent care is no longer appropriate or necessary.

The time period within which the decision is required to be rendered will begin on the date that the request is filed with Us in accordance with Our procedures under First and Second Level appeals above; without regard to whether all the information necessary to make the determination accompanies the filing. A notification of a decision, in a manner calculated to be understood by the aggrieved person, set forth:

- (i) The titles and qualifying credentials of the person or persons participating in the expedited review process;
- (ii) A statement of the reviewers' understanding of the grievance;
- (iii) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the aggrieved person to respond further to Our position;
- (iv) A reference to the evidence or documentation used as the basis for the decision; and
- (v) If the decision involves an adverse determination, the notice shall provide: (1) The specific reason or reasons for the adverse determination; (2) Reference to the specific plan provisions on which the determination is based; (3) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request; (4) If We relied upon an internal rule, guideline, protocol or other similar criterion, effective at the time of service, to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the aggrieved person upon request; (5) If the adverse determination is based on medical necessity, an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the aggrieved person free of charge upon request; (6) If applicable, instructions for requesting: a copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with (4) above; or the written statement of the criteria for the adverse determination in accordance with (5) above; and (7) A statement describing the procedures for obtaining an external review of the adverse determination pursuant to this chapter.
- (vi) Notice of your right to further remedies allowed by law, including the right to external grievance review by an independent review organization.
- (vii) The name and address of the Indiana Department of Insurance.
- (viii) The telephone number at which you may contact a representative to obtain more information about our decision and/or the right to an external grievance review.

We will provide the notice required orally, in writing or electronically. If notice of the adverse determination is provided orally, We will provide written or electronic notice of the adverse determination within three (3) days following such oral notification.

### **External Grievance Procedure by Independent Review Organization**

We will also provide for an external grievance review. An external grievance review means that Your appeal would be referred for review by an Independent Review Organization.

You may file a written request with the Us for an external grievance review of Our determination in connection with an appeal; or denial of coverage. This request must be submitted no more than one hundred and twenty (120) days after We have notified you of the determination. We will provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

- (i) life or health; or
- (ii) ability to reach and maintain maximum function; or

(B) A standard external grievance review for a grievance not described in clause (A).

When a request is filed with Us for an external grievance review We will:

- (1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the Indiana Department of Insurance; and
- (2) We will rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

The independent review organization chosen will assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance. The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:(1) The insurer, (2) Any officer, director, or management employee of the insurer, (3) The health care provider or the health care provider's medical group that is proposing the service, (4) The facility at which the service would be provided, (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider, (6) The covered individual requesting the external grievance review. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

You will not pay any of the costs associated with the services of an independent review organization under this chapter. All costs will be paid by Us.

The independent review organization will:

- (1) For an expedited external grievance within 72 hours after the external grievance is filed; or
- (2) for a standard appeal, within fifteen (15) business days after the appeal is filed; make a determination to uphold or reverse the insurer's appeal resolution based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

When making the determination under this section, the independent review organization will apply:

- (1) Standards of decision making that are based on objective clinical evidence; and
- (2) The terms of the covered individual's accident and sickness insurance policy.

In an external grievance review We bear the burden of proving that We properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service.

The independent review organization will notify Us and You of the determination made under this section:

- (1) For an expedited external grievance, within twenty-four (24) hours after making the determination; and
- (2) For a standard external grievance within seventy-two (72) hours after making the determination.