MEDICAL EXPENSE INSURANCE

GRIEVANCE PROCEDURES

Applicability

The Insured Person or authorized representative acting on the Insured Person's behalf may file a Grievance if the Insured Person is dissatisfied with any action the Company may have taken. An informal review may also be requested if the Insured Person or authorized representative acting on the Insured Person's behalf is dissatisfied with any action taken by the Company. A Written letter can be sent to the local service center (the address is shown on the Insured Person's ID card). If the Grievance involves an Urgent Care Request, an oral Grievance may be submitted to the local service center (the phone number is on the Insured Person's ID card).

Definitions

***Grievance** means a Written appeal of an Adverse Determination or Final Adverse Determination submitted by or on behalf of the Insured Person regarding:*

- *availability, delivery, or quality of health care services regarding an Adverse Determination;*
- *claims payment, handling or reimbursement for health care services;*
- *matters pertaining to the contractual relationship between the Insured Person and the Company; or*
- *matters pertaining to the contractual relationship between a health care provider and the Company.*

***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:*

- *Could seriously jeopardize the Insured Person's life or health or the ability for the Insured Person to regain maximum function; or*
- *In the opinion of a Physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care Treatment or Service that is the subject of the request.*

Grievance Review

First Level Review

Within 180 calendar days after the date of receipt of a notice of an Adverse Determination, the Insured Person or an authorized representative acting on the

Insured Person's behalf, may file a Grievance with the Company requesting a first level review of an Adverse Determination.

The Insured Person or authorized representative acting on the Insured Person's behalf is entitled to:

- *submit Written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and*
- *receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.*

The Company will make a decision and notify the Insured Person or authorized representative acting on the Insured Person's behalf in Writing or electronically within the following timeframes:

- *for a Prospective Review, within a reasonable period of time that is appropriate given the Insured Person's medical condition, but no later than 15 calendar days after receipt of the Grievance requesting the first level review.*
- *for a Retrospective Review, within a reasonable period of time, but no later than 30 calendar days after receipt of the Grievance requesting the first level review.*

Voluntary Second Level Review

Within 60 calendar days after the date of receipt of a first level review decision involving an Adverse Determination, the Insured Person or an authorized representative acting on the Insured Person's behalf, may file a voluntary second level review.

Within five business days after receipt of a request for a second level review, the Company will send notice to the Insured Person or authorized representative acting on behalf of the Insured Person of their right to:

- *Request, within ten business days after receipt of the notice, the opportunity to appear in person before a panel of Company designated representatives;*
- *Receive from the Company, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the Insured Person's request for benefits;*
- *Present the Insured Person's case to the review panel;*
- *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;*
- *If applicable, ask questions of any of the Company representatives on the review panel; provided, the questions are governed and relevant to the*

subject matter of the second level review; and

- *Be assisted or represented by an individual of the Insured Person's choice, at the Insured Person's expense.*

Procedures for conducting the second level review:

- *The review panel will schedule and hold the second level review within sixty (60) business days after the date of receipt of the request for a second level review. The Insured Person or authorized representative acting on behalf of the Insured Person will be notified in Writing fifteen (15) business days in advance of the date of the second level review. The Company will not unreasonably deny a request for postponement of the second level review made by the Insured Person or authorized representative acting on behalf of the Insured Person.*
- *The second level review will be held during regular business hours at a location that meets the guidelines established by the Americans with Disabilities Act.*
- *In cases where an in-person second level review is not practical for geographical reasons, or any other reason, the Company will give the Insured Person or authorized representative acting on behalf of the Insured Person, the opportunity to communicate with the review panel, at the Company's expense, by conference call or other appropriate technology as determined by the Company.*
- *The review panel will provide the Insured Person or authorized representative acting on behalf of the Insured Person notice of the right to have an attorney present at the second level review.*
- *The review panel will issue a Written or electronic decision to the Insured Person or authorized representative acting on behalf of the Insured Person within five (5) business days of completing the second level review meeting.*

The decision issued will include the:

- *Titles and qualifying credentials of the reviewers on the panel;*
- *Statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;*
- *Rationale for the review panel's decision;*
- *Reference to evidence or documentation considered by the review panel in rendering its decision; and*
- *In cases concerning a Grievance involving an Adverse Determination:*
    - *Instructions for requesting a Written statement of the clinical rationale, including the clinical review criteria used to make the determination; and*
    - *If applicable, a statement describing the procedures for obtaining an external review of the Adverse Determination.*

Expedited Review of Urgent Care Requests

An expedited review will be made available in a situation where the timeframe of the first and second level review would seriously jeopardize the life or health of the Insured Person, or the ability of the Insured Person to regain maximum function. The Insured Person or authorized representative acting on behalf of the Insured Person may submit a request for an expedited review orally or in Writing.

The Company will notify the Insured Person or authorized representative acting on behalf of the Insured Person of the decision orally within 72 hours after receiving the request. Written confirmation of the decision will be sent within three (3) calendar days after providing notification of the decision if the notification was not in Writing.