ALASKA
Notice of Grievance Procedures
In accordance with Alaska
Statutes Annotated §§ 3 AAC 28.936 and 3 AAC 28.952

Please read this notice carefully to learn important information about how to file grievances with us. You have the right to ask us to assist you in filing a grievance or to review our decisions involving your requests for benefits. You may contact us at the following address:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328

I. Definitions

"Adverse Determination" means a determination by a health carrier that a health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced or terminated, or payment is not provided or made, in whole or in part. An adverse determination also means the denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a covered person's eligibility to participate in the health care insurance plan.

"Authorized Representative" means:

(A) a person to whom a covered person has given express written consent to represent the covered person;
(B) a person authorized by law to provide substituted consent for a covered person;
(C) one of the following only if the covered person is unable to provide consent:
  (i) a family member of the covered person or
  (ii) the covered person's treating health care professional;
(D) a health care professional if the covered person's heath care insurance policy requires that a request for a benefit under the plan be initiated by the health care professional; or
(E) if an urgent care request, a health care professional with knowledge of the covered person's medical condition.

"Covered Person" means a policyholder, subscriber, enrollee, or other individual participating in a health care insurance policy.

"Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding:

(a) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made under utilization review;
(b) claims payment, handling, or reimbursement for health care services; or
(c) matters pertaining to the contractual relationship between a covered person and the insurer.

"Utilization Review" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and procedures provided under a managed care plan using specified guidelines, the application of practice guidelines and retrospective review.

II. Levels of Review

The following levels of review will be available to you and/or your authorized representative.

A. Internal Level Grievance Review

A written grievance concerning any matter, or an oral complaint involving an urgent care request, including an adverse determination may be submitted by a Covered Person or his or her authorized representative, within 180 calendar days of receipt of the adverse determination. A Covered Person does not have the right to attend or to have an authorized representative in attendance at the internal level review, but the Covered Person is entitled to submit written comments, documents, records and other material relating to the request for benefits for the

reviewer(s) to consider when conducting the review. The Covered Person has the right to receive 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. We will send a written decision to the Covered Person and authorized representative no later than thirty (30) calendar days after receiving a request for internal level review. In an adverse determination involving medical necessity or appropriateness, the review of an adverse determination will be conducted by a clinical peer other than the Person or Persons who made the initial determination on the matter.

B. Expedited Grievances Involving An Adverse Determination

You or your authorized representative may request an expedited review orally or in writing. The review of an adverse determination will be conducted by a clinical peer or peers, in the same or similar specialty as would typically manage the case under review, different from those who were involved in the initial adverse determination. We will transmit all necessary information including our decision to you or your authorized representative by telephone, facsimile transmission, electronic mail, or the most expeditious method available.

An expedited review of a grievance involving an adverse determination notice will include a description of the additional material or information necessary for you or your authorized representative to complete a request including why the material or information is necessary to complete the request. We will notify you or your authorized representative of the decision no later than 72 hours after receipt of the request for the expedited review.

C. External Review

You have the right to request an external review when we send written notice of an adverse determination upon completion of our utilization review process, and, a final determination. You have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the director of the Alaska Division of Insurance by mail or personal delivery at the Alaska Division of Insurance, 550 West 7th Avenue, Anchorage, AK 99501-3567, by electronic mail to insurance@alaska.gov, or by facsimile transmission by calling (907) 269-7910.

If the Covered Person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health or the Covered Person's ability to regain maximum function, you or authorized representative may (1) file a request for an expedited external review if the adverse determination involves a denial of coverage based on determination that the recommended or requested health care service or treatment is experimental and the Covered Person's provider certifies in writing that the Covered Person has a medical condition where the timeframes would seriously jeopardize the health of the Covered Person if not promptly initiated, and at the same time a Covered Person or their authorized representative files a request for an expedited review of a grievance involving an adverse determination, the assigned independent review organization shall determine whether the Covered Person or their authorized representative will be required to complete the expedited review of the grievance before conducting the expedited external review; and (2) file the grievance under our internal grievance process. However, the Covered Person or their authorized representative may file a request for external review and will be considered to have exhausted our internal grievance process if (A) we have not issued a written decision no later than 30 days after the date of the filed grievance, and (B) you or your authorized representative have not requested or agreed to a delay.

III. Written Decision

Before issuing a decision related to the grievance, we will provide you or your authorized representative any new or additional evidence relied upon free of charge. This information will be provided sufficiently in advance of the date the decision is required to be provided to allow you or your authorized representative a reasonable opportunity to respond to us before that date.

Before issuing or providing notice of a final adverse determination based on new or additional rationale, we will provide the new or additional rationale to you or your authorized representative free of charge. This information will be provided sufficiently in advance of the date the notice of final adverse determination is to be provided to allow you or your authorized representative a reasonable opportunity to respond to us before that date.

When a decision is issued from any level of review, the following information will be included in the written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review process;

2. information sufficient to identify the claim involved including the date(s) of service, treating provider and claim amounts;

3. a statement describing the procedure code and meaning;

4. a statement of the reviewer's understanding of the grievance;

5. the decision stated in clear terms, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage used as a basis for the decision;

6. reference to the documentation used as the basis for that decision;

7. explanation of the clinical judgment for making the determination;

8. specific reason(s) for the final adverse determination including the denial code, meaning and reference to the specific plan provisions;

9. how to obtain an independent external review, and the right to bring a civil action in superior court;

10. upon request and free of charge, we will provide reasonable access to, and copies of all documents, records, any internal rule, guideline, protocol, or other similar criterion relied upon to make the adverse determination;

11. notice of your right to contact the Alaska Department of Insurance

You always have the right to contact the Alaska Department of Insurance at any time if you have a question or concern regarding your coverage under this contract. The Alaska Department may be contacted:

In Writing:	Alaska Division of Insurance 550 West 7th Avenue, STE 1560 Anchorage, AK 99501-3567
Phone:	(907) 269-7900
E-Mail:	insurance@alaska.gov
Facsimile:	(907) 269-7910
TTY/TDD:	711 or (800) 770-8973

Additional Rights
If your claim has been denied in whole or in part, by an external appeal agency and if you have exhausted your administrative remedies, you shall be entitled to have your claim reviewed from the beginning in the superior court.

You may call us at 877-897-4328 for assistance with plan information because of language or physical impairment needs. Translation services, including Braille, are available upon request.

IV. Cultural and Linguistic Support
Spanish: Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 800-487-5553.

Tagalog: Libreng serbisyong pang-wika. Maaaring humingi ng interpreter na magbabasa para sa inyo ng mga dokumento sa inyong wika. Kung kailangan ng tulong, mangyaring kami ay tawagan sa numerong nakasulat sa inyong ID o sa 800-487-5553.

We want to be sure this information is helpful to you. We are sending it in a culturally and linguistically appropriate manner as described in the Affordable Care Act and 45 CFR 147.136 (e). We can provide interpreting services through our toll-free Customer Service line shown in Section III. For Spanish only, you may call 1-800-487-5553 and speak directly to an employee who is proficient in the Spanish language. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print materials for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.