Connecticut
Notice of Grievance Procedures

This notice contains important information about the appeal process available to you. If you have a question about your benefits, the payment of a claim or to file a complaint, please contact:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328
402-309-2579 (FAX)

You also have the right to contact Connecticut state agencies to assist you:

State of Connecticut Insurance Department
Consumer Affairs
P.O. Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
www.ct.gov/cid

Office of Healthcare Advocate
PO Box 1543
Hartford, CT 06144
1-866-HMO-4446
email: healthcare.advocate@ct.gov

I. Definitions

"Adverse Determination" means a determination made by us or our designee that a request for a benefit has been reviewed and, based upon the information provided, does not meet our requirement for medical necessity, or is considered experimental and the benefit is therefore denied or reduced.

"Grievance" means an oral, written, or electronic complaint submitted by you or your designated representative regarding claims payment or handling, including adverse determinations.

"Designated Representative" means a person, including the treating provider or a person to whom you have given written consent to represent you or a person authorized by law, including a guardian, agent under a power of attorney, or a proxy.

'"Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.' References to physician and medical practice will be interpreted as dentist and dental practice as applicable to the dental benefits covered under this policy.

II. Internal Grievance Review

You may submit an oral, written, or electronic grievance concerning any matter, including an adverse determination. You may designate the provider(s) to whom we will send a copy of our review decision. A written decision will be sent no later than sixty (60) working days after we receive your request. A clinical peer will conduct internal reviews of an adverse determination. The same person or persons who made the initial decision on the matter will not conduct the internal review.

Although no preauthorization is required before you receive benefits, an Expedited Review can be arranged for a review of a pre-treatment estimate of benefits for care not yet received should the grievance be related to urgently required treatment.

III. Written Decision

The following information will be included in our written decision:

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

2. a statement of our understanding of the grievance;

3. the decision stated in clear terms, with the contract basis or medical rationale used as a basis for the decision;

4. a description of our review procedures and the related time limits;

5. a description of any additional material or information that might be necessary, to clarify the request for benefits and an explanation of why such material or information is necessary;

6. either the specific rule, or guideline, relied upon in making the benefit decision, or a statement that a copy of the rule or guideline, will be provided free of charge upon request;

7. either an explanation of the scientific or clinical judgment for the benefit decisions based on medical necessity, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

8. notice of your right to contact the Connecticut Insurance Commissioner and the Office of the Healthcare Advocate.