**Notice of Grievance Procedures**

**In accordance with Chapter 44, Article 73 - Health Carrier Grievance Procedure Act of the Nebraska Insurance Code**

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

Please read this notice carefully for important information about how to file grievances with your insurer. You always have the right to contact the Nebraska Department of Insurance if you have a question or concern regarding your coverage under this policy. The Nebraska Department of Insurance may be contacted:

| | |
|---|---|
| In Writing: | Nebraska Department of Insurance<br>1526 K Street, Suite 200<br>Lincoln, NE 68508-2734 or<br>PO Box 82089<br>Lincoln, NE 68501-2089 |
| By Phone: | 402-471-2201 or<br>877-564-7323 - Consumer Affairs Hotline |

We are available to help you in filing a grievance, reviewing benefit decisions and reviewing claim payments. We will provide copies of any records or information related to your question, including the clinical basis for any adverse determinations, such as criteria, standards, or clinical indicators. Such information will be provided to you upon request and at no charge.

## I. Definitions

"Adverse Determination" means a determination by us that a benefit has been reviewed and, based upon the information provided, does not meet the plan protocols for medical necessity or appropriateness and the benefit is therefore denied or reduced.

"Covered Person" means the policyholder, provider, enrollee, claimant or a designated representative.

"Grievance" means a written complaint on behalf of an insured person submitted by a Covered Person as described above regarding:

(a) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination;

(b) claims payment, handling, or reimbursement for health care services;

(c) matters pertaining to the contractual relationship between a covered person and the insurer.

## II. Our Internal Review

A written grievance concerning any matter can be sent to the Quality Control address listed above. You or your representative may submit written comments, documents, or other information in support of an appeal. We will provide a written decision within 15 working days of receipt of the grievance and all information necessary for our review. The person or persons reviewing the grievance will not be the same person or persons who made the initial benefit determination or who handled the matter that is the subject of the grievance. Additionally, we will provide the name, phone number and address of the person who will be coordinating the appeal.

If a decision cannot be made within 15 working days due to circumstances beyond our control, we may take up to an additional 15 working days. We will provide written notice to the Covered Person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

The time requirement for us to reach a decision for a standard review of an adverse determination is 15 working days.

**A. Our Written Decision**

We will include the following information in our written decision:

1. the names, titles and qualifying credentials of the persons participating in the grievance review;
2. a statement of the reviewer's understanding of the grievance;
3. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision;
4. notice of the Covered Person's right to contact the Nebraska Department of Insurance.

**B. Urgent Matters**

Our policies have no requirements for pre-authorization of benefits. However, we offer a Pre-Treatment Review of benefits if a Covered Person would like to get an idea of the benefits to be paid prior to seeking treatment. If a Covered Person has a grievance about a pre-treatment estimate decision, and the matter is considered urgent by the treating provider, an Expedited Review will be provided. We will provide a decision and notice of the expedited review to the covered person within 72 hours after the review is started. In the rare event a grievance review of a pre-treatment benefit estimate is requested for an emergency situation, we will respond to a telephone request within 30 minutes.