NEW HAMPSHIRE
Grievance Procedures

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

Please read this notice carefully for important information about how to file grievances with us at the above address. You have the right to ask us to assist you in filing your grievance or to review our decisions regarding your benefits.

We will, of course, be available to you to discuss the position we have taken and answer your questions. You may reach us by calling the customer service number located in this notice or the number on the back of your member identification card, if you have one.

If you have been unable to resolve your concern and are a resident of New Hampshire or have a New Hampshire issued policy, you may take this matter up with the New Hampshire insurance department, it maintains a service division to investigate complaints at:

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301

The New Hampshire insurance department can be reached toll-free by dialing:

1-800-852-3416
1-800-735-2964 (TDD)

I. Definitions

"Covered Person" means you or your covered Dependents. "You" or "Your" in this Notice may apply to you, your Dependents, or your authorized representative.

"Grievance" means a written complaint submitted by you or by a person, including, but not limited to, a provider, authorized in writing to act on your behalf regarding:

(a) The availability, delivery, or quality of plan services;

(b) Benefits or claims payment, handling, or reimbursement for covered services; or

(c) Matters pertaining to the contractual relationship between you and us.

"Complaint" means any written correspondence expressing dissatisfaction with the activities of the company or any persons involved in the solicitation, sale, service, or execution of any transaction.

"Adverse Determination" means a determination that the availability of a benefit has been reviewed and based on the information provided, does not meet our requirements for medical necessity, appropriateness, level of care or effectiveness, and the requested benefit is therefore denied, reduced or terminated.

II. Levels of Review

You may ask us to review our decisions about your benefits. In general, the following levels of review are available:

First Level Grievance Review
Second Level Grievance
Review Expedited Grievance
Review External Review

For all levels of review, the person or persons reviewing the grievance will be different from those who handled the matter previously and will not be under the prior reviewer's direct supervision. These levels of review are discussed more fully below:

A. First Level Grievance Review

We will carefully review any grievance you or your representative submit. We will respond to you in writing within 15 days after we receive the grievance and all information necessary for our review.

B. Second Level Grievance Review

If you are not satisfied with the result of the First Level Grievance Review, you or your representative can submit another written grievance and we will review it as a Second Level Grievance. We will respond to you in writing within 30 days of the initial date of filing the appeal or grievance.

C. Expedited Grievance Review

Our plan does not require approval in advance of a benefit, so an Expedited Grievance Review is not likely to be needed for the limited scope benefits covered under our plans. However, we would be glad to provide an expedited review in situations where the standard time frames above could seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. The following procedures would apply:

1. The person(s) performing the expedited review will not be the same person(s) making the initial Adverse Determination and will not be subordinate to or the supervisor of the person involved in the initial determination.

2. We will make a decision and notify you as quickly as the medical condition requires, but not more than 72 hours after the review is commenced. If the expedited review is being reviewed at the same time that care is provided, the service shall be continued without liability to you until you have been notified of the determination.

3. We will provide written confirmation of our decision within 2 business days of providing notification of that decision, if the initial notification was not in writing.

4. We will provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

5. If there is still a difference of opinion after the expedited review, you or your representative may submit a written grievance. We will respond as quickly as the medical condition requires, but not more than 72 hours after the grievance is submitted.

D. External Review

You have the right to independent External Review when all of the following conditions apply:

1. The request for External Review is for an adverse determination.
2. The internal review procedures have been completed, unless:

a. an urgent medical condition requires an Expedited External Review;
b. we agree to submit the determination to independent External Review prior to completion of internal review; or
c. we did not provide a written decision from a First, Second or Expedited Review in the required time frames.

3. Your request for External Review is submitted to the Commissioner of Insurance within 180 days of our final determination, or within 180 days of when such final determination was due.
4. The Adverse Determination does not relate to any health care services that are excluded from the External Review provisions, which are those services, provided by or through:
   a. Medicaid, the State Children's Health Insurance Program, Medicare, or services provided under these programs, but through a contracted health insurer;
   b. all other government-sponsored health insurance or health services programs; or
   c. health benefit plans that are self-funded by employers.
5. The request for External Review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

Determinations relating to health care services provided through Medicaid, the state Children's Health Insurance Program (Title XXI of the Social Security Act), Medicare or services provided under these programs through a contracted health carrier shall not be reviewed under this chapter, but shall be reviewed pursuant to the review process provided by applicable federal or state law, except where those services are provided through private insurance coverage pursuant to the marketplace premium assistance program under RSA 126-A:5, XXV in which case all provisions of this chapter shall apply.

Expedited External Review - An Expedited External Review is available when your treating health care provider certifies to the Commissioner of Insurance that adherence to the time frames noted above would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

E. Written Decision

When a decision is issued from either a First Level or Second Level Grievance Review, the following information will be included in the written decision:

1. The credentials of the persons participating in the Grievance Review process, including the name of the professional consultant for grievances related to clinical matters;
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. The offer for you to request any such materials at no charge; and
5. For First Level Reviews, a description of the process to obtain a Second Level Grievance Review and the time frame for review;
6. Following a Second Level Review, a description of the process to obtain an External Review, when available, and the time frames for requesting such review; and
7. Your right to contact the New Hampshire Department of Insurance as described above or to seek other legal actions available to you.

If a written decision has not been issued within the required time frames following a First, Second or Expedited Review, then we will provide you with a statement of your right to request an External Review as described in Section D above.