Notice of Internal Grievance Procedures

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

Please read this notice carefully. This notice contains important information about the internal grievance process established by your insurer. Please feel free to contact us for any questions or concerns regarding your coverage. You also have the right to contact either of the following Vermont Health Care agencies for assistance:

Consumer Services Section
Vermont Division of Health Care Administration
802-828-2900
1-800-964-1784 (toll-free)

Office of the Health Care Ombudsman
1-800-917-7787 (toll-free)

I. Definitions

“Adverse determination” means a determination by a health insurer that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

“Appealable decision” means a decision by a health insurer to deny, reduce or terminate health care coverage or to deny payment for a health care service where the decision to be reviewed requires the insurer to expend at least $100.00 for the service, the insured has exhausted all internal appeals required relating to the decision, and the decision is based on one of the following reasons:

1. The health care service is a covered benefit that the health insurer has determined to be not medically necessary.
2. A limitation is placed on the selection of a health care provider that is claimed by the insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and regulations.
3. The health care treatment has been determined to be experimental or investigational or an off-label use of a drug.
4. The health care service involves a medically-based decision that a condition is preexisting.

"Complaint or appeal" means an oral or written complaint made by or on behalf of an insured to a health insurer, including a request for reconsideration of the insurer’s decision to deny an insured’s request for reimbursement for, or coverage of, a service that the insurer believes is or was not medically necessary or is not a covered service.

II. Levels of Review

The following levels of review will be available to a covered person.

First Level of Review, Second Level of Review, External Review

A. First Level Review

A written complaint or appeal concerning any matter, including an adverse determination may be submitted by a covered person. A written decision to the covered person will be provided within 30 calendar days after receiving a grievance and all information necessary for the insurer's review of the grievance. The person or persons reviewing the grievance will not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance.

B. Second Level Review

In any case where the first level grievance review process docs not resolve a difference of opinion between the insurer and the covered person, a written request may be submitted for a second level review. The covered person has the right to meet with one or more of the reviewers, at the covered person's request, either in person or by telephone before a final determination on the complaint or appeal is made. The member's treating provider, if requested by the member, is entitled though not required to participate in such meeting or call.

The insurer shall issue a written decision to the covered person within 7 calendar days of completing the review. All written decisions following second level reviews will be sent within 45 calendar days after receiving the request for a second level review.

C. External Review

If the complaint or appeal is an "appealable decision" as defined above, the covered person has the right to request an independent external review. The covered person has 90 days following the second level review decision to request an independent external review.

The covered person has the right to use outside assistance during the review process and to submit evidence relating to the health care service. The covered person shall pay a filing fee which shall not be more than $25.00. Other costs of the external review shall be paid by the insurer. The insurer shall not retaliate against the covered person for exercising their right to an external review.

To request an independent external review, the covered person or their representative should contact:

Division of Health Care Administration
External Appeals Program
89 Main Street – Drawer 20
Montpelier, VT 05620-3601