

## **Massachusetts Notice of Inquiry and Grievance Procedures**

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

Please read this notice carefully. This notice contains important information about how to make inquiries and/or file grievances with your insurer. Also, you always have the right to contact the Massachusetts Division of Insurance if you have a question or concern regarding your coverage under this contract. The Massachusetts Division of Insurance may be contacted through their Consumer Hotline at 1-617-521-7794.

### **I. Definitions**

“Grievance” means any written complaint submitted to the insurer by or on behalf of an insured person concerning any aspect or action of the insurer, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services and administrative operations.

“Adverse Determination” means a determination by a carrier to deny, reduce, or modify the availability of any health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness, level of care or effectiveness.

### **II. Internal Grievance Process**

#### **1. Filing a Grievance**

You may file a grievance by phone, in person, by mail, or by electronic means. We will provide you or your authorized representative, if any, a written resolution of a grievance within thirty (30) business days of receipt of the oral or written grievance.

#### **2. Written Decision**

In the case of a grievance which involves an adverse determination, our written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental and/or vision practice philosophy and will also include:

1. An identification of the specific information upon which the adverse determination was based;
2. Discuss the insured’s presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and
3. Reference and include applicable clinical practice guidelines and review criteria.

#### **3. Reconsideration**

We will always provide the opportunity to reconsider a final decision where relevant information was received too late to review within the thirty (30) business daytime limit or was not received but expected to become available within a reasonable time period.

We will review a reconsideration and provide our written response as soon as possible following receipt of the additional information, but we agree to provide such response no later than thirty (30) business days following your request for reconsideration.

You always have the right to contact the Department of Insurance:

**Division of Insurance  
One Federal Street, Suite 700  
Boston, MA 02110-2012  
(617) 521-7794  
(877) 563-4467**

**Massachusetts Health Policy Commission – Office of Patient Protection  
50 Milk Street, 8<sup>th</sup> Floor  
Boston, MA 02109  
(800) 436-7757**