

## **COLUMBIAN LIFE INSURANCE COMPANY**

Home Office: Chicago IL

Administrative Service Office: Vestal Parkway East, P.O. Box 1381

Binghamton, NY 13902-1381

**(Herein called We, Our, Us, and Company)**

### **Wisconsin Internal Grievance and External Review Process Information Packet**

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your health benefit plan. Any reference to "you" or "your" automatically extends to any authorized representative acting on your behalf.

**THIS DISCLOSURE FORM IS ONLY A SUMMARY. THE INSURANCE POLICY, CERTIFICATE OR EVIDENCE OF COVERAGE SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**

### **GRIEVANCE PROCESS SUMMARY**

#### DEFINITIONS.

**"Adverse Determination"** means a determination that a) an admission, availability of care, continued stay, or other covered service has been reviewed and denied, reduced or terminated on the basis that the treatment is not medically necessary, consistent with generally accepted medical standards, provided in a setting appropriate for the condition, or does not meet the health benefit plan's requirement for level of care and effectiveness; or b) the proposed treatment has been reviewed and denied on the basis the treatment was experimental or investigational.

**"Compelling Reason"**. A Covered Person or the Covered Person's authorized representative may file a request for Independent Review without first exhausting our internal grievance process if the request for Independent Review demonstrates to the satisfaction of the Commissioner of Insurance a) the potential delay in receipt of a health care service until after the Covered Person or the Covered Person's authorized representative exhausts the internal grievance process and obtains a Grievance Decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or b) the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others, or c) you and your health benefit plan agree to proceed directly to Independent Review.

**"Grievance"** means any dissatisfaction with the provision of services or claims practices of Columbian Life Insurance Company which offers a health benefit plan or its administration by Student Assurance Services, Inc., Our Administrator, that is expressed in writing to us by a Covered Person or on behalf of a Covered Person. Such term also includes any dissatisfaction relating to covered services provided by preferred network providers or dissatisfaction relating to an Adverse Determination.

**"Grievance Decision"** means a final determination by us that arises from an appeal of an Adverse Determination or any Grievance filed with us under our internal grievance process.

**"Request for Independent Review"**. A Covered Person or the Covered Person's authorized representative may file a request for Independent review in accordance with Wisconsin law if such Covered Person or Covered Person's authorized representative has received an Adverse Determination and has exhausted our internal grievance process.

## **GRIEVANCE**

You have the right to file a Grievance in writing for any provision of services or claim practices of Columbian Life Insurance Company which offers a health benefit plan or its administration by Student Assurance Services Inc, our Plan Administrator.

If you have a problem or concern, you should first call the customer service toll free number on your ID Card. A customer service representative will work with you to help you understand your coverage or resolve your problem or concern as quickly as possible. If you disagree with the decision or explanation given, you may submit a written request for a review through our internal grievance process. Each type of review is discussed in more detail under the section titled "Levels of Review" below.

**We do not certify or verify benefits or make decisions for treatment or a service not yet provided.**

You may initiate the internal grievance process by contacting our Plan Administrator, Student Assurance Services, Inc. at the address shown below. You may also contact our Grievance Coordinator at the address or phone number for Columbian Life Insurance Company shown below. You do have the right to:

- Submit written comments, documents, records, and other material relating to the review;
- Receive upon request, free of charge, reasonable access to and copies of all documents relevant to your request for benefits relating to the determination that resulted in the claim denial or disenrollment.
- Request an Independent review without first exhausting the grievance process if the request for Independent review demonstrates a Compelling Reason to do so.

You may appear in person to present written or oral information. If you choose to meet with and question the decision makers in person, we will notify you in writing on the time and place of the grievance meeting at least 7 days before the meeting.

Within 5 working days after we have received your written Grievance, we will mail an acknowledgement to you, confirming receipt of your Grievance. If we do not have sufficient information or written authorization to complete the grievance process, you will be notified that we cannot proceed with our review unless additional information is provided. We will assist you in gathering the necessary information without further delay. The review and response to your Grievance will be completed within 30 days following the receipt of the Grievance. The time period for completing the Grievance review may be extended an additional 30 days if agreed to

in writing. Such extension will include the reason your Grievance is not resolved, the date resolution may be expected, and the reason additional time is needed.

Our Grievance Decision will be provided to you in writing. Said notice shall:

- The titles and credentials of the person or persons participating in the review process and responsible for the decision;
- A statement of the reviewer's understanding of your grievance;
- The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail;
- A reference to the evidence or documentation used as the basis for the decision;
- For a decision involving an Adverse Determination:
  - The specific reason or reasons for the adverse determination;
  - A reference to the specific plan provisions on which the determination was based;
  - A statement if we relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination;
  - If appropriate, an explanation of the scientific or clinical judgment for making the determination; and
  - Your right to request an Independent Review and information on the Independent Review process.
- A statement of your right to contact the Commissioner of Insurance at any time for assistance.

**Grievances can be sent to the following parties:**

Columbian Life Insurance Company  
PO Box 1381  
Vestal Parkway East  
Binghamton, NY 13902  
Attn: Grievance Coordinator  
(607) 724-2472 or (800) 452-0555 (toll free in New York State) or  
(800) 423-9765 (toll free outside New York State)  
fax (607) 723-7701

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

**You can also contact the Office of the Commissioner of Insurance and file a complaint:**

State of Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P O Box 7873  
Madison, Wisconsin 53707-7873  
(608) 266-3585 or (800) 236-8517; or [www.oci.state.wi.gov](http://www.oci.state.wi.gov)

**1. Levels of Review**

There are two levels of review that you may request from us involving your requests for services or your requests to have your claims paid. The levels of Grievance reviews are:

- Grievance Panel Review
- Retrospective Review

You also may have the right to an Independent Review of our Grievance Decision regarding an Adverse Determination. Refer to the section below for requesting an Independent Review.

## **A. Grievance Panel Review**

### **1. Eligibility**

#### **a. Claim for a covered service already provided:**

You may appear in person to present written or oral information to our grievance panel. If you choose to meet with and question the decision makers in person, you may submit your written request to:

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

We will send you written notification of the time and place of the grievance meeting at least 7 calendar days before the meeting. Reasonable accommodations will be made to allow you to participate in the meeting.

### **2. Decision:**

A Grievance Decision will be made within 10 days following the date of the grievance panel meeting. The grievance panel will consist of three or more persons, including at least one individual authorized to take corrective action and at least one insured member other than the grievant, if an insured member is available to serve on the grievance panel. The panel will not include the person who ultimately made the initial determination. The panel may, however, consult with the ultimate decision maker. The panel may consult with a licensed health care provider with expertise in the field relating to the Grievance, if appropriate.

#### **a. Denial upheld**

The panel's Grievance Decision to you will be signed by one voting member of the panel and will include a written description of position titles of panel members involved in the decision. If you are not satisfied with our decision, you have the right to request a review under the Retrospective Review grievance process. If the decision to uphold the denial of an Adverse Determination, you have the right to request an Independent Review.

#### **b. Denial reversed**

If we determine that the covered services should have been provided, or your claim should have been paid, we shall authorize the services or pay the claim.

**B. Retrospective Review**

**1. Eligibility**

**a. Claim for a covered service already provided:**

You have the right to file a written request for Retrospective Review of your Grievance or Adverse Determination by sending the request to:

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

Within 5 business days after receiving your Grievance request, we shall send you written acknowledgement showing your request was received.

**2. Decision**

We will review your request and make a Grievance Decision within 30 calendar days after the date your Grievance was received.

If we do not have sufficient information to complete the Grievance review, written notice will be provided to you. An extension for a period of not longer than 30 calendar days for making a final Grievance Decision may be agreed to in writing. The Grievance will not be reviewed by the same person(s) who was involved in the initial claim denial or handled the matter that is subject of the Grievance.

If the Grievance request involves Adverse Determination, we shall designate a health care provider who has appropriate training and experience in the field of medicine involved in the medical judgment to evaluate the your grievance. The grievance will not be reviewed by the same person or health care provider who was involved in the initial adverse determination. In conducting the review, we shall take into consideration all comments, documents records and other information regarding the request for services submitted by you, without regard to whether the information was submitted or considered in making the initial Adverse Determination.

**a. Denial upheld**

If we continue to agree that the covered services should have been denied, we shall send you a written notice of our Grievance Decision.

**b. Denial reversed**

If we determine that the covered service should have been provided, or that your claim should have been paid, we will authorize the service or pay the claim.

## **C. Independent Review**

### **1. Eligibility**

#### **a. Claim for a covered service already provided:**

If you are not satisfied with the outcome of your Grievance, you have the right to file a written request for Independent Review for Adverse Determinations. You must send your request within 4 months from the date of the Grievance Decision was received or from the date the notice of the grievance panel decision was received, whichever is later. The treatment must be a covered benefit under your health benefit plan, and the total cost of the denied treatment must exceed the dollar amount published annually by the Commissioner of Insurance. This amount is disclosed in the notice sent to you for our Grievance Decision. You may send your request to:

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

We will provide you with a current listing of independent review organizations (IRO) certified by the Commissioner of Insurance from which to choose. You must first exhaust the internal Grievance process unless you have a Compelling Reason to bypass the internal grievance process. You must pay \$25 to the IRO that you choose. This fee will be refunded to you if the IRO reverses the Grievance Decision. We will notify the Commissioner of Insurance and the IRO of your request for Independent Review within 2 days of receiving your request.

### **2. Decision**

Within 5 business days of receiving your request for Independent Review, we will send the IRO all relevant medical records and other documentation used in making the Grievance Decision. The IRO has 5 business days to review the information and to request any additional information from us or you. After the IRO receives the additional information, the IRO has 30 business days to make a decision.

Any new information the IRO receives from you or the attending provider shall be provided to us for the opportunity to review our Grievance Decision. If we determine that the covered service should have been provided, or that your claim should have been paid, The Independent Review process is terminated.

All information provided to the IRO is reviewed by a clinical peer reviewer who must be an expert in the in the treatment of your medical condition and knowledgeable about the recommended health care service. The IRO reviewer must be unbiased and have no affiliation to your health benefit plan. The written decision by the IRO will include the question or issue that

was referred for review, description of the qualifications of the IRO reviewer, and the clinical rationale or explanation of the IRO's decision, including supporting evidence and a clear statement of the decision. The decision will be signed by the IRO reviewer. We will comply with the decision of the IRO.

**a. Denial upheld**

If the IRO upholds the Adverse Determination, the IRO will provide written notice to you and us.

**b. Denial reversed**

If the IRO reverses our Grievance Decision, we will authorize the service or pay the claim. We will pay the reasonable fees and costs of the IRO in conducting an Independent Review in accordance with the IRO's fee schedule approved by the Commissioner of Insurance. The fees will be paid within 30 days of receipt of the written invoice or billing records from the IRO.

**II. Obtaining Medical Records**

**A. Requesting Medical Records**

Wisconsin law permits you to ask for a copy of your medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

**B. Designated Decision Maker**

If you have a designated health care provider, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care provider or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

**C. Confidentiality**

Medical records disclosed will remain confidential.

**III. Contact Person at Each Level of Review**

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

**IV. Name and Title of Person Responsible for Processing the Review**

Student Assurance Services, Inc.  
P.O. Box 196  
Stillwater, MN 55082  
Attn: Claim Supervisor/Grievance Coordinator  
Phone: (651) 439-7098 or (800) 328-2739  
Fax: (651) 439-0200

## **V. Documentation for a Grievance**

If you decide to file a Grievance, you must give the person who will be responsible for processing the Grievance any material justification or documentation for the Grievance at the time the Grievance is filed. You must also give that person the address and phone number where you can be contacted.

## **VI. Confidentiality**

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

## **VII. Receipt of Documents**

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. As discussed above in Section V, "properly addressed" means your last known address.

## **VIII. Complaints to the Wisconsin Division of Insurance**

You have the right to file a written complaint to the Office of the Commissioner of Insurance regarding an insurance problem with your insurance company or agent. Send your complaint to:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707  
1-800-236-8517 or 608-266-0103