NORTH DAKOTA GRIEVANCE PROCEDURES

A copy of these procedures is available on The Company's website.

I. Definitions

A. *Adverse benefit determination* means:
  1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:
    a. Deductible credits; coinsurance; co-pay; provider network reductions or exclusions, or other cost sharing requirements;
    b. Any instance where the health plan pays less than the total expenses submitted resulting in claimant responsibility;
    c. A benefit denial, reduction or termination resulting from the application of any *utilization review*;
    d. An otherwise covered benefit that is denied as not medically necessary or appropriate;
    e. An otherwise covered benefit that is denied as experimental or investigational;
    f. A denial of benefits based on whether a service can effectively be provided in network;
  2. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the health plan, including any decision to deny coverage at time of application or placing a medical rider; and
  3. Any *rescission* of coverage, including offering the option of accepting a medical rider in lieu of *rescission* (whether or not the *rescission* has an adverse effect on any particular benefit at that time).

B. *Authorized representative* means:
  1. A person to whom a claimant has given express written consent to represent the claimant;
  2. A person authorized by law to provide substituted consent for a claimant; or
  3. A family member of the claimant or the claimant's treating health care professional when the claimant is unable to provide consent.
  4. For purposes of these procedures, a reference to a claimant may also refer to an *authorized representative*.

C. *Post-service claim* means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

D. *Pre-service claim* means any claim for benefits for medical care or treatment that requires the approval of the health plan in advance of the claimant obtaining the medical care.

E. *Rescission* means a cancellation or discontinuance of coverage that has a retroactive effect.

F. *Urgent care claim* means:
   1. Any claim that a physician with knowledge of the claimant's medical condition determines is an *urgent care claim* to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function.
   2. In the opinion of a physician with knowledge of the claimant's medical condition, any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
   3. Any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function. Whether a claim is an *urgent care claim* will be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

G. *Utilization review* means a system for prospective, retrospective, and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state. *Utilization review* does not include elective requests for clarification of coverage.

II. Internal Review of *Adverse Benefit Determination*s

A. General Rules Applicable to All Appeals:
   1. Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits.
   2. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.
   3. A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
   4. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.
   5. The claimant will receive from the health plan, as soon as possible, any new or additional evidence considered by the reviewer. The health plan will give the

claimant 10 calendar days to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information.

6. The claimant will receive from the health plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The health plan will give the claimant 10 calendar days to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.
7. Review of the appeal will be conducted by an individual selected by the health plan who was not the individual who made the initial *adverse benefit determination* and is not the subordinate of the original reviewer.
8. A health plan providing benefits for an ongoing course of treatment is required to provide continued coverage pending the outcome of an appeal. This means that a health plan cannot reduce or terminate benefits without providing advance notice and an opportunity for advance review.
9. The internal appeal process must be exhausted before the claimant may request an external review unless:
   a. The health plan provides a waiver of this requirement;
   b. The health plan fails to follow the appeal process; or
   c. The claimant files an *urgent care claim* external appeal at the same time as an *urgent care claim* internal appeal.

B. Request: Claimants have 180 calendar days following receipt of an initial notification of an *adverse benefit determination* to file for an internal appeal.

C. Requests for Review of *Urgent Care Claim*s: An expedited review may be requested orally or in writing for *adverse benefit determination*s involving *urgent care claim*s that have not yet been rendered.

D. Reviewer's Requirements:
   1. If the *adverse benefit determination* involves medical necessity or appropriateness, the appeal determination will be made by a physician or, if appropriate, a licensed psychologist, trained in the relevant specialty and who was not consulted in connection with the original *adverse benefit determination*.
   2. For all other *adverse benefit determination*s based in whole or in part on a medical judgment, the health plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical issue and who was not consulted in connection with the original *adverse benefit determination.*
   3. If the appeal concerns a *rescission* action, a panel of individuals who were not involved in the original *adverse benefit determination* will review the appeal.
   4. All other *adverse benefit determination*s will be reviewed by an impartial person who was not involved in making of the original *adverse benefit determination*.

E. Resolution Timeframe and Notification of Determination:

1. Appeals will be resolved and the claimant will be notified of the determination
   a. For *urgent care claim*s, as soon as possible, taking into account the medical exigencies, but no later than **72 hours** after receipt of the request for appeal;
   b. For *pre-service claim*s, within **30 calendar days** after receipt of the request for appeal; and
   c. For *post-service claim*s, within **60 calendar days** after receipt of the request for appeal.
2. If the appeal is upheld or modified, the appeal decision will include:
   a. The specific reason(s) for the adverse benefit determination;
   b. Reference to the specific plan provisions on which the benefit determination is based;
   c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
   d. If applicable, a description of the external review procedures, including a statement that the claimant may present written evidence and written testimony as part of the external review process;
   e. The claimant may have a right to bring a civil action under state or federal law;
   f. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
   g. If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
   h. The date of service;
   i. The health care provider's name;
   j. The claim amount;
   k. The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
   l. The health plan's denial code with corresponding meaning;
   m. A description of any standard used, if any, in denying the claim;
   n. That assistance is available by contacting the specific state's consumer assistance department, if applicable;
   o. A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable;
   p. The identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;

q. A clear explanation of the decision; and
r. A copy of the form that authorizes the health plan to disclose protected health information, if applicable.

III. Internal Review of All Other Complaints

Any written complaint submitted by a covered person or a provider regarding any aspect of the plan besides *adverse benefit determination*s will be handled according to the standard internal grievance procedures.

IV. External Review of *Adverse Benefit Determination*s Involving Medical Judgment or *Rescission*s

A. Request:
1. An external review is available for:
   a. An *adverse benefit determination* involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;
   b. A determination that a treatment is experimental or investigational if it is ensured that adequate clinical and scientific protocols are taken into account as part of the external review for determinations involving experimental or investigative claims for benefits; and
   c. An *adverse benefit determination* involving the cancellation or discontinuation of coverage that has a retroactive effect. For purposes of this paragraph, an *adverse benefit determination* does not include a denial, a reduction, a termination, or a failure to provide or make payment related to a claimant's eligibility for benefits under the terms of coverage.
2. A claimant must first exhaust the internal appeals process unless:
   a. The health plan provides a waiver of this requirement;
   b. The claimant is considered to have exhausted the internal appeals process; or
   c. The claimant has filed an expedited external review at the same time as an expedited internal appeal.
3. A claimant has 4 months after receipt of notice of an *adverse benefit determination* to request an external review in writing to the health plan or the commissioner at:

North Dakota Insurance Department
600 E. Boulevard Avenue
Bismarck, ND 58505-0320
Phone: (800) 247-0560

B. Request for Expedited External Review: An expedited external review is available for *adverse benefit determination*s that involve:
1. An admission, availability of care, a continued stay, or a health care service for which the claimant received emergency services but has not been discharged from the facility; or
2. A medical condition for which the standard external review timeframes would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function.

C. Process:
   1. The commissioner will assign the external review to an independent review organization (IRO) on a random or rotational basis.
   2. The claimant will be notified that they have up to 5 business days to submit additional written information to the IRO for consideration. Any additional information submitted by a claimant to an IRO for consideration in any external review must also be forwarded to the health plan within 1 business day of receipt by the IRO.
   3. The health plan must provide benefits, including making payment, pursuant to the final external review decision without delay, regardless of whether the health plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

D. Resolution Timeframe and Notification of Determination: The IRO shall provide written notice to the commissioner, the claimant, and the health plan within 45 days (72 hours for expedited) of the IRO's receipt of the request for external review. For expedited reviews, if the notification is not in writing, the IRO shall provide written confirmation of the decision within 48 hours after the oral notification.

E. General Information:
   1. A determination made by the independent external reviewer is binding on the parties.
   2. The health plan will pay for the costs of the external review performed by the IRO.