NOTICE OF VERMONT APPEAL RIGHTS

This notice summarizes your appeal rights when we have denied coverage for health care services. Vermont law outlines three types of appeal processes: **first level grievance, voluntary second level grievance and independent external review**. To make an informed decision about whether to pursue your appeal rights, please review the following information carefully.

FIRST LEVEL GRIEVANCES

If we have denied your request to cover a health care service, in whole or in part, you or someone you name to act for you (your "authorized representative") may request a first level grievance at no cost to you or your provider.

A first level grievance must be requested no later than 180 days after you receive our initial denial notice. However, if you wish to extend coverage for ongoing treatment of urgently needed services ("urgent concurrent" services) without interruption beyond what we have approved, you must request the review at least 24 hours prior to the expiration of the approved services.

Requests for a first level grievance may be submitted to us verbally or in writing. If you have a disability or English is not your primary language, we will provide other ways for you to file a grievance and take part in the grievance process, if you request. If you decide to seek a first level grievance, contact us at:

Appeals Coordinator [Insert Name and/or Other Title]
[Insert Name of Managed Care Organization or Insurer]
Street Address
City, State, ZIP
Toll-free Telephone Number
Fax number

If you have information or written comments that you would like us to consider, please send them with your grievance request. Send your information to the address shown above, fax it to the number above, or call the toll-free number above ***[MCOs can add additional contact information, if any, here]***. Be sure to include your contact information (including a telephone number if you have one).

You have a right to review our information related to your grievance. If you would like copies of all documents, records, rules, guidelines, protocols and other information relevant to your grievance, we will send these materials to you at no cost within two business days, or immediately if the review is urgent.

Assuming that we have received all information necessary to decide your grievance, it will be decided within the time frames shown below based on the type of service that is the subject of your grievance:

- Grievances related to "urgent concurrent" services (services that are part of an ongoing course of treatment involving urgent care that have been approved by us) will be decided within 24 hours of receipt;
- Grievances related to urgent services that have not yet been provided will be decided within 72 hours of receipt;
- Grievances related to mental health and substance abuse services and prescription drugs that have not yet been provided will be decided within 72 hours of receipt.
- Grievances related to non-urgent mental health and substance abuse services and prescription drugs that have not yet been provided will be decided within 72 hours of receipt, unless a grievance qualifies for an exception to the expedited 72-hour timeframe, in which case it has to be decided within 30 days of receipt. Grievances that qualify for an exception to the expedited 72-hour time frame include grievances that:
    - were not treated as urgent during the initial review;
    - relate to treatment that can continue uninterrupted during non-expedited reviews;
    - relate to services scheduled far enough into the future so that non-expedited reviews can be completed before the scheduled date; or

  - we believe the review does not have to be expedited for medical reasons (and you and your provider agree);
- Grievances related to non-urgent services that have not yet been provided (other than mental health and substance abuse services and prescription drugs) will be decided within 30 days of receipt; and
- Grievances related to services that have already been provided will be decided within 60 days of receipt.

Note: Grievances related to our decision to terminate services or a course of treatment previously approved by us will be decided before your benefits are reduced or terminated. If you are appealing a prescription drug denial or an exception to pharmacy benefit requirement, you may be eligible for an interim supply of your prescription. [***MCOs can add contact information for interim supplies here***.]

VOLUNTARY SECOND LEVEL GRIEVANCES

If your first level grievance resulted in another denial, in whole or in part, you or your authorized representative may request a voluntary second level grievance at no cost to you or your provider.

A voluntary second level grievance must be requested no later than 90 days after you receive our first level grievance denial notice. However, if you wish to extend coverage for ongoing treatment for urgently needed services ("urgent concurrent" services) without interruption beyond what we have approved, you must request the review at least 24 hours prior to the expiration of the approved services.

Your rights, who to contact, and the time frames for deciding voluntary second level grievances are the same as those outlined above for first level grievances. In addition, you and/or your authorized representative have the opportunity to participate in a telephone meeting or an in-person meeting with the reviewer(s) for your second level grievance, if you wish. If you are unable to take part in the meeting in the way that has been offered, we will offer the other way to you. You may ask your treating provider(s) and any other person(s) that you choose to take part in the meeting. If the scheduled meeting date does not work for you, you may request that the meeting be postponed and rescheduled.

If you decide to ask for a voluntary second level grievance, it will have no effect on your rights to any other benefits.

INDEPENDENT EXTERNAL REVIEW

You may have the right to have a denial reviewed by an independent external review organization. These organizations are not connected with us; the independent external review program is administered by the Vermont Department of Financial Regulation.

An independent external review must be requested no later than 4 months or 120 days (whichever is longer) after you receive our first level or voluntary second level grievance denial notice. However, if you wish to extend coverage for ongoing treatment for urgently needed services ("urgent concurrent" services) without interruption beyond what we have approved, you must request the review within 24 hours after you receive our first level or voluntary second level grievance denial notice. You also have the right to simultaneously file for an expedited first or voluntary second level grievance and an expedited external review.

Independent external reviews are referred to Independent Review Organizations (IRO). If you are denied a service or treatment or payment of a service or treatment and have filed a grievance with us which was denied, you may appeal our decision. To make a request, contact the Vermont Department of Financial Regulation during normal business hours (Monday through Friday, 7:45 am to 4:30 pm (EST), except State and Federal holidays) at:

NOTICE OF VERMONT APPEAL RIGHTS

External Appeals Program – Division of Insurance
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101
Telephone: 1-800-964-1784 (toll-free)

If your request is urgent or an emergency, you may call 24 hours a day, 7 days a week, including holidays. A recording will tell you how to reach the person on call. If your request is not urgent, the Department will provide you with a form to submit your request.

RIGHT TO BRING LEGAL ACTION

If your health insurance plan is subject to a federal law called ERISA, you may have the right to bring legal action under section 502(a) of ERISA. Ask your employer's benefit administrator if this applies to you. You do not have to pursue a voluntary second level grievance or independent external review prior to bringing legal action under section 502(a) of ERISA.

ADDITIONAL ASSISTANCE

The Office of Health Care Advocate's telephone hotline service can also provide help to Vermonters who have problems or questions about health care and health insurance. Contact them at:

Office of Health Care Advocate
264 North Winooski Avenue
Burlington, VT 05402
Telephone: 800-917-7787 (toll-free) or 802-863-2316
TTY: 888-884-1955 or 802-863-2473

For questions about your rights or for assistance, you can also contact the Employee Benefits Security Administration at **1-866-444-3272**.

If you are not satisfied with how we resolved a complaint, you may send a complaint about our service review activities to:

Consumer Services - Insurance Division
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101
Telephone: 1-800-964-1784 (toll-free)