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TITLE 760 DEPARTMENT OF INSURANCE

LSA Document #02-124(F)

DIGEST

Amends 760 IAC 1-59 to set filing and implementation requirements for internal grievance procedures. Effective 30 days after filing with the secretary of state.

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SECTION 1. 760 IAC 1-59-1 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-1 Authority
Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10

Sec. 1. This rule is adopted and promulgated pursuant to the authority granted by **IC 27-8-28-20,** IC 27-13-10-13, and IC 27-13-35-1. *(Department of Insurance; 760 IAC 1-59-1; filed Sep 30, 1998, 2:17 p.m.: 22 IR 446, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2326)*

SECTION 2. 760 IAC 1-59-2 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-2 Purpose
Authority: IC 27-8-28-20; IC 27-13-10-13
Affected: IC 27-8-28-19; IC 27-13-8-2; IC 27-13-10

Sec. 2. The purpose of this rule is to prescribe the following for **insurers and** health maintenance organizations:
(1) The form for filing information with the commissioner, as required by **IC 27-8-28-19 and** IC 27-13-8-2(a).
(2) Requirements for notifying enrollees of grievance procedures.
(3) Requirements for filing, investigating, and resolving grievances and appeals.
(Department of Insurance; 760 IAC 1-59-2; filed Sep 30, 1998, 2:17 p.m.: 22 IR 446, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2326)

SECTION 3. 760 IAC 1-59-3 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-3 Definitions
Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-3; IC 27-13-1-12; IC 27-13-1-32; IC 27-13-10-7

Sec. 3. The definitions in **IC 27-8-28 and** IC 27-13 shall apply for purposes of this rule, in addition to the following:
~~(1) "Commissioner" means the commissioner of the department of insurance.~~

~~(2) "Department" means the department of insurance.~~

~~(3)~~ **(1)** "Enrollee", as defined in IC 27-13-1-12, includes "subscriber" as defined in IC 27-13-1-32 **and "covered individual" as defined in IC 27-8-28-3.**

~~(4)~~ **(2)** "Grievance" means **the following:**

(A) For a health maintenance organization and a limited service health maintenance organization, any dissatisfaction expressed by or on behalf of an enrollee of a health maintenance organization or a limited service health maintenance organization regarding the:

~~(A)~~ **(i)** availability, delivery, appropriateness, or quality of health care services;

~~(B)~~ **(ii)** handling or payment of claims for health care services; or

~~(C)~~ **(iii)** matters pertaining to the contractual relationship between:

~~(i)~~ **(AA)** an enrollee and a health maintenance organization or a limited service health maintenance organization; or

~~(ii)~~ **(BB)** a group or individual contract holder and a health maintenance organization or a limited service health maintenance organization;

and for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(B) For an insurer, any dissatisfaction expressed by or on behalf of a covered individual regarding:

(i) a determination that a service or a proposed service is not appropriate or medically necessary;

(ii) a determination that a service or a proposed service is experimental or investigational;

(iii) the availability of participating providers;

(iv) the handling or payment of claims for health care services; or

(v) matters pertaining to the contractual relationship between a:

(AA) covered individual and an insurer; or

(BB) group policyholder and an insurer;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

~~(5)~~ **(3)** "Grievance procedures" means written procedures established and maintained by a health maintenance organization, ~~or~~ a limited service health maintenance organization, **or an insurer** for filing, investigating, and resolving grievances and appeals.

~~(6)~~ **(4)** "Major population group" means a racial or ethnic group for whom English is not the primary language and whose members comprise at least ten percent (10%) of the health maintenance organization's enrollees.

(Department of Insurance; 760 IAC 1-59-3; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)

SECTION 4. 760 IAC 1-59-4 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-4 Reports

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-19; IC 27-13-8-2

Sec. 4. ~~(a)~~ On or before March 1 of each year, **an insurer,** a health maintenance organization, **and a limited service health maintenance organization** must submit **electronically** to the department a grievance procedure report for the preceding calendar year on the form set forth in section 14 of this rule. A health maintenance organization **and a limited service health maintenance organization** may submit the information required by IC 27-13-8-2(a)(2) and IC 27-13-8-2(a)(3) concurrent with this filing.

~~(b) The report must be prepared in tabular form on paper measuring eight and one-half (8½) inches by eleven (11) inches.~~

~~(c) The report also must be submitted on a disk formatted for Microsoft Excel and the disk must accompany the paper copy.~~

(Department of Insurance; 760 IAC 1-59-4; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)

SECTION 5. 760 IAC 1-59-5 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-5 Grievance register

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10-3

Sec. 5. (a) **An insurer,** a health maintenance organization, and a limited service health maintenance organization shall maintain written records that document certain information about all grievances received during a calendar year (the grievance register).

(b) The grievance register shall contain, at a minimum, the following information for each grievance:
(1) A general description of the basis for the grievance using the categories in block 3 of the grievance procedures report set forth in section 14 of this rule.
(2) Date received.
(3) Date investigated or reviewed.
(4) Date resolved.
(5) Description of resolution.
(6) Date appeal, if any, was received.
(7) Date of appeals hearing or review.
(8) Date appeal was resolved.
(9) Description of resolution of the appeal.
(10) Name of enrollee and enrollee's representative, if any, who filed, or upon whose behalf was filed, the grievance.
(11) Names and titles of all persons who investigated, reviewed, and resolved the grievance.

(c) **An insurer,** a health maintenance organization, or **a** limited service health maintenance organization shall retain each grievance register until the commissioner has conducted an examination of the organization and adopted a final report of the examination that contains a review of the register for the calendar year covered by the grievance register. *(Department of Insurance; 760 IAC 1-59-5; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2327)*

SECTION 6. 760 IAC 1-59-6 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-6 Establishment of grievance procedures; filing with and review by commissioner
Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28-17; IC 27-13-2; IC 27-13-10; IC 27-13-34-8; IC 27-13-39-3

Sec. 6. (a) **An insurer,** a health maintenance organization, and a limited service health maintenance organization shall establish and maintain grievance procedures.

(b) A copy of the grievance procedures, including all forms used in filing and reviewing grievances, shall be included with any application for a certificate of authority submitted to the department.

(c) Any material modifications to the grievance procedures subsequent to the submission of the application shall be filed with the commissioner not more than fifteen (15) days after the adoption of the modification.

(d) The grievance procedures shall require the following:
(1) **A health maintenance organization must provide written or oral acknowledgment of a grievance or appeal no more than three (3) business days after receipt. Insurers must provide** written or oral acknowledgment of a grievance or appeal **no more than five (5) business days after receipt.** The acknowledgment must include the name, address, and telephone number of an individual to contact regarding the grievance and the date the grievance was filed.
(2) Investigation of any grievance or appeal in accordance with written procedures and the requirements of section 10 of this rule.
(3) Documentation of the substance of the grievance and all actions taken by the **insurer or** health maintenance organization regarding the grievance or appeal, including notification, acknowledgment, investigation, and resolution.
(4) Written notification to the enrollee of:
(A) resolution of the grievance or appeal;
(B) the right to appeal the resolution;
(C) information about how, when, and where to appeal the resolution; and
(D) the right to further remedies allowed by law, in the case of an appeal of a grievance resolution.

(e) The grievance procedures shall include procedures to assist enrollees and representatives of enrollees in filing grievances and appeals, including provisions for assistance to persons with literacy, language, physical, health, or other impediments.

(f) The grievance procedures shall include standards that meet the requirements of **IC 27-8-28-17 or** IC 27-13-10 and section 10 of this rule for timeliness in acknowledging, investigating, and resolving grievances and appeals and that accommodate the clinical urgency of the enrollee's situation. The standards for timeliness shall address:

(1) the likelihood of death, permanent injury, improvement, or deterioration of health status; and

(2) the ability to reach and maintain maximum function.

(g) The grievance procedures must require expedited review of a grievance or appeal if the time periods set forth in section 10 of this rule would seriously jeopardize the life or health of an enrollee or the enrollee's ability to reach and maintain maximum function.

(h) ~~The~~ **An HMO's** grievance procedures must comply with the requirements of IC 27-13-39-3 with respect to any grievance regarding denial of coverage for a treatment, procedure, drug, or device on the grounds that it is experimental.

(i) The grievance procedures shall require and describe the process for the appointment of at least one (1) individual who has sufficient experience, knowledge, and training to appropriately resolve a grievance or appeal.

(j) The requirements of subsections (d) through (i) do not apply to a limited service health maintenance organization. *(Department of Insurance; 760 IAC 1-59-6; filed Sep 30, 1998, 2:17 p.m.: 22 IR 447, eff Jan 1, 1999; errata, 22 IR 759; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2328)*

SECTION 7. 760 IAC 1-59-7 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-7 Notice to enrollees

Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1

Affected: IC 27-8-28; IC 27-13-7-5; IC 27-13-9-4; IC 27-13-10; IC 27-13-39

Sec. 7. (a) **An insurer and** a health maintenance organization shall provide the following to each enrollee:

(1) Information about health care services ~~offered~~ **covered** by the **insurer or** health maintenance organization, including the following:

(A) A description of ~~in-plan and out-of-plan~~ covered services, **including any services subject to a network restriction.**

(B) A description of any limitations on payment for or coverage of health care services, including definitions of commonly used terms.

(C) Criteria used to determine whether to deny coverage.

(D) A description of exclusions from coverage.

(E) An explanation of any limitation on coverage for experimental treatments, procedures, drugs, or devices, including the following:

(i) A description of the process used to determine any limitation.

(ii) A description of the criteria the **insurer or the** health maintenance organization uses to determine whether a treatment, procedure, drug, or device is experimental.

(2) Information about where additional information on access to services can be obtained.

(3) Information about the **insurer's or the** health maintenance organization's grievance procedures, including the toll free telephone number described in section 8 of this rule.

(4) Information about the **insurer's or the** health maintenance organization's structure.

(5) Information about costs for which the enrollee is responsible.

(6) Information about financial incentives and disincentives given by the **insurer or the** health maintenance organization to providers.

(b) Except as provided in subsection (f), the information required by subsection (a) must be:

(1) included in or provided with the evidence of coverage required under IC 27-13-7-5 or any member handbook within the time periods set forth in subsection (f); and

(2) provided to any potential enrollee upon request.

(c) The information required by subsection (a)(3) shall be included on any notice to enrollees regarding the provision, limitation, or denial of health care services.

(d) The toll free telephone number shall be prominently displayed on any enrollment verification card.

(e) **This subsection is applicable to health maintenance organizations only.** A brief statement of an enrollee's right to file a grievance with the health maintenance organization, including the toll free telephone number, shall be posted by a participating provider in a conspicuous public location in each place where health care services are provided by or on behalf of the health maintenance organization. The notice shall be in bold face type at least one-half (½) inch in height. The statement must contain the following or substantially similar language: "We participate in the following health maintenance organizations: [list names of and toll free telephone numbers of participating HMOs]. If you have coverage through one (1) of these HMOs and have a complaint or grievance, you may call the HMO at its toll free number listed above. The HMO is required by law to try to resolve your complaint or grievance. You may also register a complaint with the Indiana Department of Insurance at 1-800-622-4461. The HMO cannot retaliate against you or your provider for making a complaint.".

(f) The information required by subsection (a) must be provided to enrollees not later than one hundred twenty (120) days after the effective date of this rule. During the period beginning one hundred twenty (120) days after the effective date of this rule and ending on the first renewal date of the enrollee's plan that occurs on or after the effective date of this rule, the information required by subsection (a) may be provided to enrollees in an addendum to or statement separate from the documents described in subsections (b) and (d). *(Department of Insurance; 760 IAC 1-59-7; filed Sep 30, 1998, 2:17 p.m.: 22 IR 448, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2329)*

SECTION 8. 760 IAC 1-59-8 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-8 Toll free telephone number
Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-9-4; IC 27-13-10-5

Sec. 8. (a) **An insurer and** a health maintenance organization shall establish a toll free telephone number through which grievances and appeals may be filed and information about grievance procedures obtained.

(b) An individual who is knowledgeable about the **insurer's or the** health maintenance organization's grievance procedures and any applicable state laws and regulations must be available to respond to calls received at the toll free telephone number at least forty (40) normal business hours per week. The toll free telephone number must be answered by an answering machine or similar device at all other times.

(c) Any messages left through the toll free telephone number must be returned on the following business day by a qualified individual.

(d) The toll free telephone number must accept grievances in English and the languages of the major population groups served by the health maintenance organization. *(Department of Insurance; 760 IAC 1-59-8; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2329)*

SECTION 9. 760 IAC 1-59-9 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-9 Filing grievances
Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10

Sec. 9. (a) A grievance may be filed with **an insurer or** a health maintenance organization orally, including by telephone, or in writing, including by facsimile or electronic means of communication.

(b) A grievance may be filed with a limited service health maintenance organization, in writing, including by facsimile or electronic means of communication.

(c) A grievance is considered to be filed on the day and time it is first received orally or in writing by the **insurer,** health maintenance organization, or limited service health maintenance organization.

(d) A grievance may be filed by an enrollee, or a representative of an enrollee, including a health care provider acting on behalf of an enrollee. *(Department of Insurance; 760 IAC 1-59-9; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)*

SECTION 10. 760 IAC 1-59-10 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-10 Standards for timely review and resolution of grievances
Authority: IC 27-8-28-20; IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-8-28; IC 27-13-10-7; IC 27-13-10-8

Sec. 10. (a) Minimum standards for timely review and resolution of grievances filed with **an insurer or** a health maintenance organization are as follows:

(1) **A health maintenance organization shall provide** oral or written acknowledgment of a filed grievance ~~must be provided~~ to an enrollee not more than three (3) business days after the grievance is filed. **An insurer shall provide oral or written acknowledgment of a filed grievance to an enrollee or an enrollee's representative not more than five (5) business days after the grievance is filed.**

(2) ~~Resolution of~~ **A health maintenance organization shall resolve** a grievance not more than twenty (20) business days after the grievance is filed. **An insurer shall resolve a grievance not more than twenty (20) business days after the insurer receives all information reasonably necessary to complete the review.**

(3) Written notification to an enrollee of the resolution of a grievance not more than five (5) business days after the resolution.

(4) The time period set forth in subdivision (2) may be extended if **an insurer or** a health maintenance organization is unable to resolve a grievance within the specified time period due to circumstances beyond the **insurer's or the** health maintenance organization's control. An enrollee must be notified in writing of the reason for the delay not more than nineteen (19) business days after the grievance is filed. The **insurer or the** health maintenance organization shall issue a written notification of the resolution of the grievance not more than ten (10) business days after the notification to the enrollee of the delay.

(b) As used in this rule, "circumstances beyond the **insurer's or the** health maintenance organization's control" means the following:

(1) The failure of a provider that is not a participating provider to provide within fifteen (15) days of the filing of the grievance information that is requested by the **insurer or the** health maintenance organization and is necessary to adequately review and investigate the grievance.

(2) The failure of an enrollee to provide additional information requested by **the insurer or** the health maintenance organization that is necessary to resolve the grievance within fifteen (15) days of the filing of the grievance.

(c) Minimum standards for timely review and resolution of grievance resolution appeals filed with **an insurer or** a health maintenance organization are as follows:

(1) Oral or written acknowledgment **by a health maintenance organization** to an enrollee of a filed appeal not more than three (3) business days after the appeal is filed. **Oral or written acknowledgment by an insurer to a covered individual of a filed appeal not more than five (5) business days after the appeal is filed.**

(2) Resolution of the appeal not more than forty-five (45) business days after the appeal is filed.

(3) Written notification to an enrollee of the resolution of an appeal not more than five (5) business days after the resolution.

(Department of Insurance; 760 IAC 1-59-10; filed Sep 30, 1998, 2:17 p.m.: 22 IR 449, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)

SECTION 11. 760 IAC 1-59-11 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-11 Grievance resolution notice
Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-10-7

Sec. 11. The written notification of resolution required by section 10(a) and 10(c) of this rule shall contain the following:

(1) A statement of the **insurer's or the** health maintenance organization's understanding of the enrollee's grievance.

(2) A description of the resolution reached by the **insurer or the** health maintenance organization stated in clear terms and the contract basis or medical rationale for the resolution stated in sufficient detail for the enrollee to respond further to the **insurer's**

or the health maintenance organization's position.

(3) A reference to the evidence or documentation used as the basis for the resolution.

(4) A statement of the procedures governing an appeal, including how to file an appeal.

(5) In the case of a resolution of an appeal of a grievance resolution, a notice of the enrollee's right to further remedies allowed by law.

(6) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the resolution of the grievance or the right to and procedures governing an appeal or further remedies allowed by law.

(Department of Insurance; 760 IAC 1-59-11; filed Sep 30, 1998, 2:17 p.m.: 22 IR 450, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2330)

SECTION 12. 760 IAC 1-59-12 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-12 Appeal of a grievance resolution

Authority: IC 27-8-28; IC 27-13-10-13; IC 27-13-35-1

Affected: IC 27-8-28; IC 27-8-17; IC 27-13-10-8

Sec. 12. (a) The health maintenance organization shall appoint a panel of individuals who have sufficient experience, knowledge, and training to appropriately resolve an appeal. If the grievance involves the proposal, refusal, or delivery of a health care procedure, treatment, or service, the panel must include at least one (1) individual who:

(1) has knowledge in the medical condition, procedure, or treatment at issue;

(2) is in the same licensed profession as the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance; and

(3) is not involved, **in any manner,** in the matter that is the basis of the underlying grievance **or have**

~~(b) The following individuals may not be appointed to a panel:~~

~~(1) Any individual who was involved in the matter that is the basis of the underlying grievance.~~

~~(2) Any individual who was involved in the investigation or resolution of the underlying grievance.~~

~~(3) Any individual who has~~ a direct business relationship with

the enrollee or the health care provider who proposed, refused, or delivered the health care procedure, treatment, or service that is the basis of the underlying grievance.

~~(c) A health maintenance organization shall not be required to appoint a panel to resolve an appeal pursuant to IC 27-13-10-8 if the appeal involves substantially the same issue or issues previously reviewed in an appeal conducted pursuant to IC 27-8-17.~~

(b) In the case of an appeal of a grievance described in section 3(2)(B)(i) or 3(2)(B)(ii) of this rule, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel shall include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

~~(d)~~ **(c) An insurer and** a health maintenance organization shall require the panel to meet at a time during normal business hours and place convenient to an enrollee who wishes to appear before or otherwise communicate with the panel, to the extent reasonably possible. **An insurer and** a health maintenance organization shall notify an enrollee whose grievance is the subject of an appeal not less than seventy-two (72) hours prior to the meeting of the panel. ~~pursuant to IC 27-13-10-8.~~ The enrollee may waive the seventy-two (72) hour notice of the meeting of the panel. *(Department of Insurance; 760 IAC 1-59-12; filed Sep 30, 1998, 2:17 p.m.: 22 IR 450, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2331)*

SECTION 13. 760 IAC 1-59-14 IS AMENDED TO READ AS FOLLOWS:

760 IAC 1-59-14 Grievance procedures report form
Authority: IC 27-13-10-13; IC 27-13-35-1
Affected: IC 27-13-8-2

Sec. 14. The form required by section 4(a) of this rule is the following:

~~HMO~~ GRIEVANCE PROCEDURES REPORT

NAME: _____

FOR REPORTING PERIOD January 1, ____ through December 31, ____

Block 1 REPORTING ~~HMO~~ **COMPANY** INFORMATION

NAIC Group Code:	
Assumed business name(s):	
Address:	
General business telephone number:	
Grievance reporting - toll free number:	
Name, ~~and~~ telephone number, **and e-mail address** of contact person for grievance procedures:	
Languages in which grievances may be filed:	
Total number of Indiana enrollees at beginning of reporting period:	
Total number of Indiana enrollees at end of reporting period:	
Service area (use applicable county codes; **if the entire state, please indicate entire state rather than list all county codes):**	

Block 2 GENERAL INFORMATION

Number of grievances filed		Number of appeals filed	
Number of grievances resolved		Number of appeals resolved	
Number of grievances resolved with ~~HMO~~ **Company** position upheld		Number of appeals resolved with ~~HMO~~ position upheld	
Number of grievances resolved with ~~HMO~~ **Company** position overturned		Number of appeals resolved with ~~HMO~~ **Company** position overturned	
Number of grievances pending		Number of appeals pending	
Time to resolve grievances (average number of days)		Time to resolve appeals (average number of days)	

INTERNAL GRIEVANCE AND APPEALS INFORMATION

Block 3 NOTE: A grievance should not be recorded in more than one (1) category.

Basis	Number Filed	Company Position Upheld? Yes (#): No (#):	Number Pending	Average Number Of Days To Resolve	Appealed ? Yes (#): No (#):	Company Position Upheld On Appeal? Yes (#): No (#):	Number Of Appeals Pending	Average Number Of Days To Resolve Appeals
DENIAL OR LIMITATION OF COVERED HEALTH CARE SERVICES								
Inpatient services								
Outpatient services								
Emergency services								
Mental or behavioral services								
Home health care								
Prescription drugs								
Equipment or supplies								
Laboratory services								
Experimental treatments								

Other services								
HEALTH CARE PROVIDERS **(for HMOs, LSHMOs, and Insurers with Network plans)**								
Quality of health care services								
No referral or expired referral								
Problem with particular provider not available								
Problem with number of providers available								
Problem with type of providers available								
Problem with provider location								
Problem getting appointment								

OTHER BASIS FOR GRIEVANCE								
Difficulty in enrolling/ other enrollment issues								
Problem with claim payment or handling								
Benefits limited or excluded								
Timeliness of decision making								
Other (attach additional sheets if necessary)								

Block 4 DESCRIPTION OF GRIEVANCE PROCEDURES

Please describe your grievance procedures. Attach additional sheets as necessary:

Block 5 DESCRIPTION OF APPEALS PROCEDURES

Please describe your appeals procedures. Attach additional sheets as necessary:

(Department of Insurance; 760 IAC 1-59-14; filed Sep 30, 1998, 2:17 p.m.: 22 IR 451, eff Jan 1, 1999; filed Feb 17, 2003, 9:57 a.m.: 26 IR 2331)

SECTION 14. 760 IAC 1-59-13 IS REPEALED.

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