Member grievance and appeals process

First step—Filing a grievance

Adverse Benefit Determination means**:**

- Denial of eligibility for or termination of enrollment in a health benefit plan;
- Rescission or cancellation of a policy or certificate;
- Source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;
- Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or
- Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854

Grievance means a written complaint regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination based on the decision of the plan through a prior authorization; or
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between the member and the plan.
- In writing, for an internal appeal or an external review, or in writing or orally, for an expedited response described in ORS 743.804(2)(d) or an expedited external review

The first step is filing a grievance (complaint). You or your Authorized Representative may file your grievance, in writing. Within five business days of receiving a grievance, we will send you or your Authorized Representative an acknowledgment letter. If the grievance cannot be resolved within five business days, we will notify you in writing that additional time is required. You or your Authorized Representative will then receive a written decision within 30 days from your initial letter.

Second step—Filing a level 1 appeal

Authorized Representative: An individual who by law or by the consent of a person may act on behalf of the person.
If you remain dissatisfied after the initial grievance decision, you or your Authorized Representative have the right to file a Level 1 appeal. The appeal request must be: 1) in writing, 2) be signed, 3) include the appeal reason; and 4) be received by us within 180 days of the denial or other action giving rise to the grievance. You may use an Appeal Request Form to provide this information.

Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter. You or your Authorized Representative has the right to appear in person to talk about your appeal. The Level 1 appeal decision will be determined by an appropriate healthcare professional not previously involved in your case. You or your Authorized Representative will receive a written decision within 15 days pre-service and 30 days post-service of our receiving your appeal request.

Please Note: If you, your Authorized Representative or your treating provider believes that the request to appeal is urgent; meaning, a review decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, your appeal will be processed in an expedited manner. For urgent appeals, your treating provider may act as your Authorized Representative.

If your request for appeal meets the definition of urgent, you or your Authorized Representative may request a simultaneous expedited External Review. For more information, please refer to the section labeled Expedited Appeal Process.

Third step—Filing a level 2 appeal

If you remain dissatisfied after the Level 1 appeal decision, you or your Authorized Representative have the right to file a Level 2 appeal by writing to us within 180 days of the Level 1 appeal decision. Within five business days of receiving the appeal, we will send you or your Authorized Representative an acknowledgment letter.

You or your Authorized Representative has the right to appear in person to talk about your appeal. The Level 2 appeal decision will be determined by an appropriate healthcare professional not previously involved in your case. You or your Authorized

Representative will receive a written decision within 15 days pre-service and 30 days post-service of our receiving your Level 2 appeal. This is the final internal level of appeal; however, you may qualify for External Review which is described in the next section.

External review

External Review decisions are made by Independent Review Organizations (IRO) that is not associated with Samaritan Health Services. Your appeal will be randomly assigned to an IRO by the Oregon Insurance Division (OID).

Your appeal may qualify for an External Review (at no cost to you) if:

- the Plan does not adhere to the rules and guidelines of the process defined for the internal review;

OR

- internal appeal Levels 1 and 2 have been completed; and, the reason for the Level 2 adverse decision was:
  - based on medical necessity; or
  - for treatment determined to be experimental or investigational; or
  - for the purpose of continuity of care (no interruption of an active course of treatment under ORS 743.854)
  - delivered in an appropriate health care setting and with the appropriate level of care

OR

- you and the Plan have mutually agreed to waive the internal appeals requirement.

We must receive your written request for an External Review within 180 days of the Level 2 adverse decision.

Please Note: When you send a request for External Review, you or your Authorized Representative must submit a signed a waiver granting the IRO access to your medical records pertaining to the adverse decision. You can request the waiver form from the Plan.

If your request meets the definition of urgent as defined by law, you or your Authorized Representative may request an expedited External Review. For more information, please refer to the section labeled Expedited Appeal Process.

To apply for an External Review you must send your written request or the Appeal Request Form to us at the following address:

Samaritan Health Plans Appeals Team
P.O. Box 1310
Corvallis, Oregon 97339

Once the OID has notified the Plan of the assigned IRO, we will submit your External Review request to the IRO within 2 business days. When you are notified by the IRO that your request for External Review has been received, you will have 5 business days to submit additional information about your appeal.

The IRO will return a written decision to you or your Authorized Representative and to the Plan within the following timeframes:

- Expedited External Review - 72 hours after receipt of the request
- Standard External Review - 30 days after receipt of the request

IRO decisions are final and we are bound by their decisions. If you want more information regarding External Review, please contact our Customer Service Department at 541-768-4550; toll-free at 800-832-4580 or TTY 1-800-735-2900.

Expedited appeal process

If you believe your appeal is urgent, you, your Authorized Representative or your treating provider, may request an Expedited appeal. If the appeal request meets the definition of urgent under the law; which means, a decision made within the standard timeframe of 30 days could seriously jeopardize your life or health or your ability to regain maximum function, the appeal will be processed in an expedited manner (within 72 hours of our receiving the appeal request). If the appeal does not meet the definition of urgent, you will be notified immediately and the appeal will then be processed within the standard timeframe.

The Expedited appeal request must:

- be filed verbally or in writing within 180 days after you receive notice of the initial written pre-service denial; and
- state the reason for the appeal request; and

- state the reason an expedited decision is needed; and
- include supporting documentation necessary to make a decision.

When applicable, if you are simultaneously requesting an expedited External Review in addition to an expedited internal review, a signed waiver granting the IRO access to your medical records pertaining to the adverse decision must be included.

The internal Expedited review decision will be determined by an appropriate healthcare professional not previously involved in your case. A verbal notice of the decision will be provided to you, your Authorized Representative and your treating provider as soon as possible but no later than 72 hours of our receiving the appeal. A written notice will be mailed within one working day following the verbal notification. If you have requested a simultaneous expedited External Review, the plan will also forward your appeal to the IRO.

To apply for an Expedited review:
Send your written request, or the Appeal Request Form, to:

Samaritan Health Plans Appeals Team
P.O. Box 1310
Corvallis, Oregon 97339

Or call our Customer Service Department at
(541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900.

Appeal timeframes

Samaritan Health Plans has the following timeframes for making internal review decisions on appeals:

- 72 hours for urgent appeals
- 15 days for pre service appeals
- 30 days for post service appeals

To obtain an Appeal Request Form or a waiver granting IRO access to your medical records visit www.samhealth.org or call our Customer Service Department (541) 768-4550, toll free 800-832-4580 or TTY 1-800-735-2900.

Your appeal rights

You have the right to:

- file a grievance about and/or appeal any decision we make regarding availability, delivery or quality of health care services, or an adverse determination based on the decision of the Plan through a prior authorization, claims payment, handling or reimbursement for healthcare services or matters pertaining to the contractual relationship between the member and the Plan.
- appoint someone to act as your Authorized Representative when filing a grievance or appeal, such as a relative, friend, treating physician, advocate, attorney, or someone else who has been legally appointed.
- contact us when you:
  - do not understand the reason for the denial;
  - do not understand why the health care service or treatment was not fully covered;
  - do not understand why a request for coverage of a health care service or treatment was not approved;
  - cannot find the applicable provision in your policy;
  - want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision.
- request within 180 days of the denial, or other action giving rise to the grievance or appeal, a 1st Level of Internal Appeal.
- request within 180 days of the 1ST Level of internal appeal denial, a 2nd Level of Internal Appeal.
- a full and fair internal review of your appeal by healthcare professionals associated with us, but who were not involved in the action being appealed provide us with additional information that relates to your appeal.
- appear in person to talk about your internal levels of appeal.
- an internal review decision within 15 days for pre-service appeals, 30 days for post-service appeals and 72 hours for an expedited appeal.
- Request a copy of the information in your appeal (free of charge) regardless if it was used to make the decision.
- **file an External Review (at no cost to you) within 120 days (180 days) if applicable**.

- an External Review decision within 30 days of the IRO receiving your standard request and 72 hours for an expedited request.
- send additional information, in writing, directly to the IRO, no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review.
- an Expedited Review if you, your Authorized Representative or your treating provider believes that waiting the standard 15 day timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed.
- a simultaneous Expedited Internal and External Review, if applicable.
- information about our grievance and appeal processes. Contact our Customer Service Department at 541-768-4550; toll-free at 1-800-832-4580; TTY 1-800-735-2900; or you can write to the following address:
  Samaritan Health Plans Appeal Team
  PO Box 1310
  Corvallis, OR 97339
- **to pursue civil action in accordance to 502(a) of the Employee Retirement Income Security Act of 1974 after you have exhausted your internal levels of appeal on an adverse benefit determination.**
- **The insurer is bound to follow the decision of the IRO, and may be penalized by DCBS if it fails to do so.**
- The enrollee is financially responsible for benefits paid to or on behalf of an enrollee pursuant to ORS 743.804(2)(g) if the insurer's adverse benefit determination is upheld on appeal
- **The enrollee has the right to sue the insurer if the decision of the IRO is not implemented.**
- Other dispute options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner. To seek further assistance, contact any of the following:

  Department of Consumer &
  Business Services
  By calling (503) 947-7984 or the toll free message line at (888) 877-4894;
  By electronic mail at: cp.ins@state.or.us;
  By writing to the Oregon Division of Insurance, Consumer Advocacy Unit at:
  PO Box 14480
  Salem, OR 97309-0405

  Consumer Advocacy website:
  http://www.oregon/gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx

You may, at any time, request a copy of these materials. If requested, we will send you a copy of those materials within 30 days of your request.

- Annual summary of grievance and appeals;
- Annual summary of utilization review policies;
- Annual summary of quality assessment activities;
- The results of all publically available accreditation surveys;
- An annual summary of our health promotion and disease prevention activities;
- An annual summary of scope of network and accessibility of services.