GRIEVANCE PROCEDURES AND EXTERNAL REVIEW PROCEDURES

GRIEVANCE PROCEDURES

The following levels of review are available to Insured Persons or providers who have a complaint or a Grievance.

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:
1. The Company's decisions, policies or actions related to availability, delivery or quality of health care services;

2. Claims payment, handling or reimbursement for health care services;

3. The contractual relationship between an Insured Person and the Company; or

4. The outcome of a Noncertification as defined.

Noncertification means a determination that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, and the requested service is therefore denied, reduced or terminated. A noncertification is not a decision rendered solely on the basis that the policy does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

A noncertification includes any situation in which the Company or its designated agent makes a decision about an Insured's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the policy is affected by that decision.

The levels of review include an Informal Review and Formal Review.

INFORMAL REVIEW
An Insured Person may submit a written complaint to the Company for informal review after an event that causes a dispute.

1) If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured, the Company shall treat the request as a first-level Grievance review, except that on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner, the Company will provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.

2) If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company shall issue a written decision that includes the availability of the Commissioner's office for assistance, including the telephone number and address of the office.

3) If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company shall treat the request as a first-level Grievance review, except that on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.

FORMAL REVIEW
The Formal Review process includes a First Level, Second Level and Expedited Review Process.

FIRST LEVEL GRIEVANCE REVIEW
1) An Insured or an Insured's provider acting on the Insured's behalf may submit a Grievance.

2) The first level Grievance material must be submitted in writing by the Insured or his/her provider for consideration by the first level reviewer.

3) With the exception of Grievances concerning the quality of care received, within 3 business days after the Company receives the request for a first-level Grievance review, the Company must provide the Insured with the name, address and telephone number of the Grievance coordinator and information on how to submit written material.

4) The Insured may or may not attend this review but is not required to do so.

5) The Company will issue a written decision, in clear terms, to the Insured and, if applicable, the Insured's provider, within 30 days of the receipt of the Grievance. The person or persons reviewing the Grievance shall not be the same person or persons who initially handled the matter that is the subject of the Grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level Grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the Grievance.

b. A statement of the reviewer's understanding of the Grievance.

c. The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising the Insured of his or her right to request a second-level Grievance review and a description of the procedure for submitting a second-level Grievance.

6) For Grievances concerning the quality of clinical care delivered by the Insured's provider, the Company shall acknowledge the Grievance within 10 business days. The acknowledgement shall advise the Insured that:

a. The Company will refer the Grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and

b. State law does not allow for a second-level Grievance review for Grievances concerning quality of care.

SECOND LEVEL GRIEVANCE REVIEW

1) A second level Grievance review is available to Insureds dissatisfied with the first level Grievance review decision. An Insured or an Insured's provider acting on the Insured's behalf may submit a second level Grievance.

2) Within 10 days of the receipt of the request for the second level review, the Company will provide the following information to the Insured:

a. The name, address and telephone number of the Grievance review coordinator.

b. A statement of the Insured's rights, including the right to:

i. Request and receive from the Company all information relevant to the case;

ii. Present his/her case to the review panel;

iii. Submit supporting material prior to and at the review meeting;

iv. Ask questions of any member of the panel;

v. Be assisted or represented by a person of the Insured's choosing, including a family member, employer representative or attorney.

3) The Company will convene a second-level Grievance review panel for each request. The panel shall be comprised of persons who were not previously involved in any matter giving rise to the second-level Grievance, are not employees of the Company, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level Grievance involving a

Noncertification or clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if the Company used a clinical peer on an appeal on a first-level Grievance review panel then the Company may use one of its employees on the second-level Grievance review panel in the same matter if the second-level Grievance review panel comprises three or more persons.

4) The second level Grievance review meeting will be held within 45 days of receipt of the second level review request.

5) The Insured will receive at least 15 days notice of the second level Grievance review meeting date.

6) The Insured will have the right to full review without condition of his/her attendance at the meeting.

7) A written statement of the second level Grievance review panel's decision shall be issued to the Insured within 7 business days after the review meeting. The decision shall include:

a. The professional qualifications and licensure of the members of the review panel.

b. A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts.

c. The review panel's recommendation to the Company and the rationale behind that recommendation.

d. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.

e. In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.

f. The rationale for the Company's decision if it differs from the review panel's recommendation.

g. A statement that the decision is the Company's final determination in the matter.

h. Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED SECOND-LEVEL GRIEVANCE REVIEW PROCEDURES

1) An expedited second level review is available whether or not the initial review was expedited. The Company may require documentation of medical justification in accordance with 58-50-61(I).

2) An expedited second level review will meet the requirements for a non-expedited second level review with the following differences:

a. The review proceeding must take place and the decision communicated to the Insured within 4 business days of receiving all necessary information.

b. The review meeting must take place via conference call or the exchange of written information. Insured Persons, his/her designated representative, or a provider may contact

Bollinger, Inc.
College Claims Manager
101 JFK Parkway
Short Hills, NJ 07078-0727
Toll Free: 1-866-267-0092
Facsimile: 1-973-921-2876
Website: www.BollingerColleges.com

The Grievance Procedures describe above are voluntary. The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. The Insured may inquire in writing to the Department at: 1201 Mail Service Center, Raleigh, NC 27699-9001or by telephone at 1-800-546-5664.

EXTERNAL REVIEW

North Carolina law provides for review of Noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to the Insured, arranging for an IRO to review the Insured's case once the NCDOI establishes that the Insured's request is complete and eligible for review. The Insured or the Insured's authorized representative may request an external review. The Company will notify the Insured in writing of his/her right to request an external review each time the Insured:

1. receives a Noncertification decision, or

2. receives an appeal decision upholding a Noncertification decision, or

3. receives a second-level grievance review decision upholding the original Noncertification.

In order for the Insured's request to be eligible for external review, the NCDOI must determine the following:

1. that the request is about a Medical Necessity determination that resulted in a Noncertification decision;

2. that the Insured had coverage with the Company in effect when the Noncertification decision was issued;

3. that the service for which the Noncertification was issued appears to be a covered service under the policy; and

4. that the Insured has exhausted the Company's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, the Insured will be considered to have exhausted the internal review process if he/she has:

1. completed the Company's appeal and second level grievance review and received a written second level determination from the Company, or

2. filed a second level grievance and except to the extent that the Insured has requested or agreed to a delay, has not received the Company's written decision within 60 days of the date the Insured submitted the request, or

3. received notification that the Company has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

If the Insured's request for a standard external review is related to a retrospective Noncertification (a Noncertification which occurs after the Insured has received the services in question), the Insured will not be eligible to request a standard review until he/she has completed the Company's internal review process and received a written final determination from the Company.

If the Insured wishes to request a standard external review, he/she (or his/her representative) must make this request to NCDOI within 60 days of receiving the Company's written notice of final determination that the services in question are not approved. When processing the request for external review, the NCDOI will require the Insured to provide the NCDOI with a written, signed authorization for the release of any of their medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of the Insured's request for a standard external review, the NCDOI will notify the Insured and his/her provider of whether the request is complete and whether it is accepted. If the NCDOI notifies the Insured that his/her request is incomplete, the Insured must provide all requested additional information to the NCDOI within 90 days of the date of the Company's written notice of final determination. If the NCDOI accepts the Insured's request, the acceptance notice will include:

1. the name and contact information for the Independent Review Organization (IRO) assigned to the case;

2. a copy of the information about the Insured's case that the Company has provided to the NCDOI; and

3. notification that the Insured may submit additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO within 7 days of the date of the acceptance notice.

If the Insured chooses to provide any additional information to the IRO, the Insured must also provide that same information to the Company at the same time using the same means of communication (e.g., the Insured must fax the information to the Company if it was faxed to the IRO). When faxing information to the Company, send it to 1-973-921-2876. If mailing the information, send it to:

Bollinger, Inc.
College Claims Manager
101 JFK Parkway
Short Hills, NJ 07078-0727

Please note that this additional information may also be sent to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and the Company. The NCDOI will forward this information to the IRO and the Company within two business days of receiving the additional information.

The IRO will send the Insured written notice of its determination within 45 days of the date the NCDOI received the standard external review request. If the IRO's decision is to reverse the Noncertification, the Company will, reverse the Noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the Noncertification decision. If the Insured is no longer covered by the policy at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a Noncertification decision may be available if the Insured has a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize the life or health of the Insured or would jeopardize the Insured’s ability to regain maximum function. If the Insured meets this requirement, the Insured may make a written or verbal request to the NCDOI for an expedited review after the Insured:

1. receives a Noncertification decision from the Company and files a request with the Company for an expedited appeal, or

2. receives an appeal decision upholding a Noncertification decision and files a request with the Company for an expedited second level grievance review, or

3. receives a second-level grievance review decision upholding the original Noncertification.

The Insured may also make a request for an expedited external review if the Insured receives an adverse second-level grievance review decision concerning a

Noncertification of an admission, availability of care, continued stay or emergency care, but has not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review the Insured's request and determine whether it qualifies for expedited review. The Insured and the Insured's provider will be notified within 3 days if the request is accepted for expedited external review. If the request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if the Company's internal review process was already completed, or (2) require the completion of the Company's internal review process before the Insured may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective Noncertifications.

The IRO will communicate its decision to the Insured within 4 days of the date the NCDOI received the request for an expedited external review. If the IRO's decision is to reverse the Noncertification, the Company will, within one day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply that is the subject of the noncertification decision. If the Insured is no longer covered by the policy at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

For further information about External Review or to request an external review, contact the NCDOI at:

By Mail:
NC Department of Insurance; Healthcare External Review Program; 1201 Mail Service Center, Raleigh, NC 27699-9001
(fax)919-807-6865

In Person:
Dobbs Building; 430 N. Salisbury St.; 4th Floor, Suite 4105; Raleigh, NC
(Toll-free in NC) 1-877-885-0231
(Out of NC) 1-919-807-6860

The IRO's external review decision is binding on the Company and the Insured, except to the extent the Insured may have other remedies available under applicable federal or state law. The Insured may not file a subsequent request for an external review involving the same Noncertification decision for which the Insured has already received an external review decision.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.