

SERFF Tracking Number: TRST-125762813 State: Arkansas  
Filing Company: Trustmark Insurance Company State Tracking Number: 39878  
Company Tracking Number: 8.01350  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: GRIEV-NOTICE NB AR 7-08  
Project Name/Number: GRIEVANCE NOTICE FILING (PART 2)/8.01350

## Filing at a Glance

Company: Trustmark Insurance Company

Product Name: GRIEV-NOTICE NB AR 7-08

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: TRST-125762813

SERFF Status: Closed

Co Tr Num: 8.01350

Co Status:

Authors: Charlotte Johnson,  
Latasha Keys

Date Submitted: 08/07/2008

State: ArkansasLH

State Tr Num: 39878

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 08/16/2008

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: GRIEVANCE NOTICE FILING (PART 2)

Project Number: 8.01350

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/16/2008

State Status Changed: 08/16/2008

Corresponding Filing Tracking Number:

Filing Description:

August 4, 2008

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Deemer Date:

Rosalind Minor

Life and Health Division

Insurance Department

1200 West Third Street

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Little Rock, AR 72201-1904

RE: TRUSTMARK INSURANCE COMPANY

FEIN# 36-0792925; NAIC# 276-61425

Grievance Notice filing

Forms: GRIEV-NOTICE NB AR 7-08

Our filing#: 8.01350

Dear Ms. Minor:

Enclosed please find the above listed form for your review and approval for use in Delaware in accordance with 23-99-410. This form is new and will not replace any forms currently in use.

The form is being filed to update some of the language for clarity.

The forms are in final printed format as issued from a laser printer. We, however, use different computer publishing systems. Therefore, actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines and line wording may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate refiling for such font style variation.

Thank you for your time and effort with regard to this filing. If you have any questions or concerns, please contact me at 800-666-6977, extension 34004 or at [cjohnson@trustmarkins.com](mailto:cjohnson@trustmarkins.com).

Sincerely,

Charlotte Johnson  
Senior Compliance Analyst  
Law Department

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## Company and Contact

### Filing Contact Information

Charlotte Johnson, Senior Compliance Analyst cjohnson@trustmarkins.com  
 400 Field Drive (800) 666-6977 [Phone]  
 Lake Forest, IL 60045 (847) 615-3872[FAX]

### Filing Company Information

Trustmark Insurance Company	CoCode: 61425	State of Domicile: Illinois
400 Field Drive	Group Code: 276	Company Type:
Lake Forest, IL 60045	Group Name:	State ID Number:
(800) 666-6977 ext. [Phone]	FEIN Number: 36-0792925	

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50 per filing x 1 = \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Trustmark Insurance Company	\$0.00	08/07/2008	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
00170351	\$50.00	08/06/2008

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/16/2008	08/16/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Reviewer	Latasha Keys	08/07/2008	08/07/2008

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## **Disposition**

Disposition Date: 08/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Filing Fee form	Approved-Closed	Yes
<b>Form</b>	Grievance Notice	Approved-Closed	Yes

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**Note To Reviewer**

**Created By:**

Latasha Keys on 08/07/2008 10:21 AM

**Subject:**

Filing Fee

**Comments:**

Check will be overnighted today.

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## Form Schedule

**Lead Form Number:** GRIEV-NOTICE NB AR 7-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GRIEV-NOTICE NB AR 7-08	Other	Grievance Notice	Initial		50	GRIEV-NOTICE NB AR R7-08 final 7-30-08.pdf

## Notice of Grievance Procedures for Arkansas Residents

**Adverse Determination** means a determination by Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided the requested payment for the service is denied, reduced or terminated, because:

- The requested health care service does not meet the plan's requirements for medical necessity; or
- The requested health care service has been found to be experimental or investigational; and

The adverse determination involves treatment, services, equipment, supplies or drugs that would require the health benefit plan to expend \$500 or more of expenditures.

If You have questions about any decisions related to Your coverage, You may call Us and a Customer Service Representative will assist You.

**[LEVEL 1:** You, Your medical provider, or Your personal representative may submit a written request for a formal grievance review, if You have a complaint about any of the following:

- Trustmark's decisions, policies, or actions related to coverage of health care services;
- Claims payment or handling;
- The contractual relationship between a Covered Person and Trustmark;
- The outcome of an appeal on a denial of certification of an admission or service, or continued stay or treatment.

You may submit Your request for formal Grievance Review within **[180]** days of receiving the decision or information about which You have a complaint. Your written request should contain the issues and comments which are pertinent and should be sent or faxed to:]

Trustmark [Life] Insurance Company  
[Grievance Review ]  
[PO Box 7950]  
[Lake Forest IL 60045-7950]  
[Fax (847) 615-3937]

**[LEVEL 2:** If You are dissatisfied with the results of the Level I review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a second level grievance review within **[180 days]** of receiving the Level I decision.

A decision will be made within **[30]** calendar days after receiving Your second level Grievance Review request. We will advise You of Our final decision.]

**EXPEDITED INTERNAL REVIEW:** You, Your medical provider, or Your personal representative have the right to request an expedited review if the usual review time period would reasonably appear to seriously jeopardize the life or health of a covered person, or the ability to regain maximum function.

Upon request for an expedited review, Trustmark will immediately verify with the patient's physician that a longer time frame for a review would acutely jeopardize the life or health of the patient, or jeopardize the ability to regain maximum function. If the physician confirms this fact, either orally or in writing, then an initial determination will be made within 72 hours. Any oral determination must be confirmed in writing within 2 business days.

**STANDARD EXTERNAL REVIEW:** You, Your medical provider, or Your personal representative has the right to request an external review if a final Adverse Determination has been rendered. All requests must be submitted in writing or via electronic media to Us and be filed within 60 days after the date You receive notice of the final Adverse Determination. Upon receipt of the request, We will assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner.

The independent review organization will review the request and advise, within 5 business days whether the request is complete and accepted for external review. **If accepted for review, You and Your treating health care professional may submit in writing to the independent review organization within 7 business days following the date of receipt of the notice of acceptance, additional information and supporting documentation that the independent review organization shall consider when conducting the external review.**

When filing a request for external review, You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

**EXPEDITED EXTERNAL REVIEW:** You, Your medical provider, or Your personal representative may also request an expedited external review if 1) an Adverse Determination was made and the usual review time period would reasonably appear to seriously jeopardize the life or health of the covered person, or the ability to regain maximum function; 2) the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is “experimental” or “investigational” and Your medical provider certifies, in writing and supports such certification with reasoning, rationale, or evidence, that the recommended service or treatment would be significantly less effective if not promptly initiated; or 3) You, Your medical provider, or Your personal representative filed a Level 1 or Level 2 appeal and We did not issue a written decision within 30 days for pre-service charges or 60 days for post-service charges of receipt of the appeal request; or 4) a final Adverse Determination was rendered and the determination concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but was not yet been discharged from the facility.

The independent review organization conducting the external review shall determine if You are required to complete our internal expedited internal review process prior to conducting an expedited external review. Upon determination that You must complete the expedited internal process, the independent review organization will notify You and Your treating health care professional. If the independent review organization agrees to review the expedited external review request, a decision will be rendered by the independent external review organization within 72 hours after the date of receipt of the request.

When filing a request for expedited external review, You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

**ASSISTANCE INFORMATION:** You may contact the commissioner for assistance in resolving a grievance. The commissioner may be contacted at:

Arkansas Department of Insurance  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1904  
1-800-852-5494 or  
(501) 371-2640  
insurance.consumers@arkansas.gov



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## **Rate Information**

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## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	08/16/2008
<b>Comments:</b>		
<b>Attachments:</b>		
Reg 19 certification - TMK.pdf		
Reg 49 certification - TMK.pdf		
Flesch.pdf		
certification - TMK.pdf		
<b>Bypassed -Name:</b> Application	<b>Review Status:</b> Approved-Closed	08/16/2008
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	08/16/2008
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	08/16/2008
<b>Bypass Reason:</b> Not applicable		
<b>Comments:</b>		
<b>Satisfied -Name:</b> Filing Fee form	<b>Review Status:</b> Approved-Closed	08/16/2008
<b>Comments:</b>		
<b>Attachment:</b>		
AR Life & Health Fee Form.pdf		

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, it is compliant with the requirements of the Arkansas Insurance Rule and Regulation 19.



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Sara Lee Keller  
General Counsel and Secretary

Date: August 7, 2008

ARKANSAS

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, it is compliant with the requirements of the Arkansas Insurance Rule and Regulation 49.

  
\_\_\_\_\_  
Sara Lee Keller  
General Counsel and Secretary

Date: August 7, 2008

ARKANSAS

This is to certify the forms shown below comply with the requirements of Arkansas Stat. Ann. Sections 23-80-201 through 23-80-207, cited as the Accident and Health Insurance Policy Language Simplification Act and have achieved a Flesch reading ease score as follows:

<u>Form</u>	<u>Flesch Score</u>
GRIEV-NOTICE NB AR 7-08	50

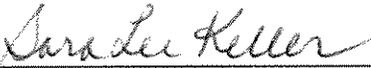


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Sara Lee Keller, General Counsel & Secretary

ARKANSAS

Trustmark Insurance Company hereby certifies that, to the best of its knowledge and belief, it is compliant with the requirements of the Arkansas Insurance Code 23-79-138.



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Sara Lee Keller  
General Counsel and Secretary

Date: August 7, 2008

ARKANSAS

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: TRUSTMARK INSURANCE COMPANY  
400 Field Drive, Lake Forest, IL 60045

Company NAIC Code: 276-61425

Company Contact Person: Charlotte Johnson

Telephone Number: 800-666-6977, Extension 34004

<u>INSURANCE DEPARTMENT USE ONLY</u>
ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, <b>per each policy, contract, annuity form</b> , per each insurer, per each filing.	* <u>  1  </u> X \$50 = \$ ** Retaliatory = \$50.00
Life and/or Disability - Filing and review of <b>each rate filing</b> or loss ratio guarantee filing, per each insurer.	* <u>    </u> X \$50 = \$ ** Retaliatory = \$
Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of <b>each certificate, rider, endorsement or application</b> if each is filed separately from the basic form.	* <u>    </u> X \$25 = \$ ** Retaliatory = \$
Life and/or Disability - Filing and review of insurer's advertisements, <b>per advertisement</b> , per insurer.	* <u>    </u> X \$20 = \$ ** Retaliatory = \$

\* These fees are payable under the new fee schedule as outlined under Rule and Regulation 57.

\*\* These fees are payable under the old fee schedule as outlined under Ark. Code Ann. 23-63-102, Retaliatory Tax.