

SERFF Tracking Number: FEMC-127881599 State: Arkansas
Filing Company: Federated Mutual Insurance Company State Tracking Number: 50436
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Group Health
Project Name/Number: GH 03 09 (02-12 ed.)/GH 03 09 (02-12 ed.)

Filing at a Glance

Company: Federated Mutual Insurance Company

Product Name: Group Health

SERFF Tr Num: FEMC-127881599 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved-
Closed State Tr Num: 50436

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Jeanette Myers

Disposition Date: 12/13/2011

Date Submitted: 12/09/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GH 03 09 (02-12 ed.)

Status of Filing in Domicile: Not Filed

Project Number: GH 03 09 (02-12 ed.)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 12/13/2011

State Status Changed: 12/13/2011

Deemer Date:

Created By: Jeanette Myers

Submitted By: Jeanette Myers

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Federated Mutual Insurance Company is filing a revised Grievance Procedure in order to comply with Rule 76 "External Review Regulation." This will replace GH 03 09 (01-12 ed.) approved by your department on 09/06/2011 under State Tracking # 49633.

Company and Contact

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Filing Contact Information

Jeanette Myers, Compliance Analyst jmmyers@fedins.com
 121 East Park Square 800-533-0472 [Phone]
 Owatonna, MN 55060 507-455-8226 [FAX]

Filing Company Information

Federated Mutual Insurance Company	CoCode: 13935	State of Domicile: Minnesota
121 East Park Square	Group Code: 7	Company Type:
PO Box 328	Group Name:	State ID Number:
Owatonna, MN 55060	FEIN Number: 41-0417460	
(800) 533-0472 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$125.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federated Mutual Insurance Company	\$125.00	12/09/2011	54392189

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/13/2011	12/13/2011

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Disposition

Disposition Date: 12/13/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Grievance and Appeals	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GH 03 09 (02-12 ed.)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/13/2011	GH 03 09 (02-12 ed.)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Grievance and Appeals	Revised	Replaced Form #: GH 03 09 (01-12 ed.) Previous Filing #: 49633		GH 03 09 _02-12 ed _.pdf

SECTION IX - GRIEVANCE AND APPEAL PROCEDURES

Words and phrases appearing in **bold type** have special meaning as set forth in Section VIII - Definitions.

1. SUBMISSION OF GRIEVANCES

Initial **grievances** based on **our** utilization review organization's (named on the back of the identification card provided to **covered persons**) denial of a pre-certification request under Section I - General Provisions, 16. Pre-Certification Requirements should be submitted to the utilization review organization as directed in their non-certification letter.

All other initial **grievances** should be submitted to the Medical Benefits & Services Appeals Department at:

Medical Benefits & Services Appeals
Federated Mutual Insurance Company
P.O. Box 328
Owatonna, MN 55060

After that review is completed, a second level **grievance** can be submitted to **our** Medical Benefits & Services Appeals Department. A **covered person** can also contact the local U.S. Department of Labor Office or insurance regulator in their state to submit a **grievance** or complaint.

A **covered person** can appoint an **authorized representative** to act on his behalf in pursuing a **grievance**. Except for a **grievance** related to an **emergency condition**, the appointment of an **authorized representative** for handling **grievances** must be in writing and signed by the **covered person**. An assignment of benefits to a **provider** is not appointment of an **authorized representative** for **grievances**.

Initial **grievances** must be submitted within 180 calendar days of the event giving rise to the **grievance**. The event giving rise to the **grievance** can be a notice of **benefit** determination, a notice of rescission of coverage, an administrative action by **us** or the provision of another service by **us**. For a **grievance** related to a notice of **benefit** determination or a notice of rescission of coverage, the date of the event is printed on the notice. For a **grievance** related to an administrative action by **us**, the date of the event is the date **we** took the administration action. For a **grievance** related to the provision of another service by **us**, the date of the event is the date **we** provided the service.

Second level **grievances** must be submitted within 60 calendar days of the date printed on the written notice of the initial **grievance** decision.

2. INITIAL GRIEVANCE PROCEDURE

When an initial **grievance** is received by **our** utilization review organization regarding treatment, services or supplies requiring pre-certification or the Medical Benefits & Services Appeals Department regarding all non-pre-certification issues, the following procedure will be used.

- a. Written acknowledgement of the **grievance** will be sent to the **covered person** and/or the **authorized representative** within 3 business days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit additional written material.
- b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.
- c. If the issue is clinical, the reviewer will consult a **physician** who was not involved in the initial review of the matter.
- d. The **covered person** will be provided with copies of any new or additional evidence or rationale considered, relied upon, or generated by **us**, prior to receiving a determination based upon new or additional evidence or rationale.
- e. An investigation will be completed and a decision made within 15 calendar days of receipt for a pre-service claim and within 30 calendar days for a post-service claim.
- f. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:
 - i. the specific reason for the utilization review organization's or **our** decision;
 - ii. the specific **policy** provisions applicable to the **grievance**;
 - iii. any internal guidelines used in making the decision;

- iv. if the decision is based on **medical necessity** or the treatment being **experimental or investigational**, notice that the clinical basis for the decision will be provided on request;
- v. information on how to obtain copies of documents the utilization review organization or **we** have on the **grievance**;
- vi. information on how to file a second level **grievance** and the right to sue after internal **grievance** procedures are completed by **us**;
- vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.";
- viii. in states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review; or
- ix. information on the right to external review by an independent review organization.

3. SECOND LEVEL **GRIEVANCE** PROCEDURE

A second level **grievance** on any matter is initiated by sending a request for review to:

Medical Benefits & Services Appeals
 Federated Mutual Insurance Company
 P.O. Box 328
 Owatonna, MN 55060

Or by calling 507-455-5200 or toll free 800-533-0472 and asking for the Medical Benefits & Services Appeals Department.

Our Medical Benefits & Services Appeals Department will complete this review.

When a second level **grievance** is received by **our** Medical Benefits & Appeals Department, the following procedure will be used.

- a. Written acknowledgement of the **grievance** will be sent to the **covered person** and/or the **authorized representative** within 3 business days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.
- b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.
- c. If the issue is clinical, **we** will consult a **physician** who was not previously reviewed the matter.
- d. The **covered person** will be provided with copies of any new or additional evidence or rationale considered, relied upon, or generated by **us**, prior to receiving a determination based upon new or additional evidence or rationale.
- e. An investigation will be completed and a decision made within 15 calendar days for a pre-service claim and within 30 calendar days for a post-service claim.
- f. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:
 - i. the specific reason for **our** decision;
 - ii. the specific **policy** provisions applicable to the **grievance**;
 - iii. any internal guidelines used in making the decision;
 - iv. if the decision is based on **medical necessity** or the treatment being **experimental or investigational**, notice that the clinical basis for the decision will be provided on request;
 - v. information on how to obtain copies of documents **we** have on the **grievance**;
 - vi. information on the right to sue after internal **grievance** procedures are completed by **us**;
 - vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.";

- viii. in states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review; or
- ix. information on the right to external review by an independent review organization.

4. EXPEDITED GRIEVANCE REVIEW

If the **grievance** relates to an **emergency condition**, an expedited review can be requested. A **covered person, authorized representative** or **provider** on behalf of a **covered person** can request expedited review.

If the **covered person, authorized representative** or **provider** requests an expedited review, an initial determination will be made within 72 hours of the request. Within 3 business days of the initial determination, the **covered person, authorized representative** or **provider** may request further review by **us**. If further review by **us** is requested, the final determination will be made within 30 calendar days. The initial determination and final determination on an expedited **grievance** may be made orally but will be followed up in writing within 3 business days.

5. EXPEDITED REVIEW PROCEDURES

a. Standard External Review Procedures

The **covered person** has a right to request an external review of an "adverse determination" or "final adverse determination" by an Independent Review Organization (IRO) approved by the Arkansas Insurance Commissioner.

- i. The external review is only available after the completion of **our** internal **grievance** procedure unless:
 - (1) the **covered person** has filed an appeal involving an "adverse determination" and has not received a written determination within 30 calendar days of **our** receipt of a pre-service claim or within 60 calendar days of **our** receipt of post-service claim and the **covered person** has not consented to the delay;
 - (2) **we** and the **covered person** agree to waive **our grievance** procedure; or
 - (3) the IRO agrees to waive **our grievance** procedure because the **covered person's** health condition would be jeopardized by requiring use of **our grievance** procedure.
- ii. To request an external review, the **covered person** and/or the **authorized representative** must send a written or electronic request for external review to the Commissioner at the following address:

Arkansas Insurance Commissioner
1200 West 3rd Street
Little Rock, AR 72201
1-800-282-9134
- iii. External review must be requested within four (4) months after the **covered person** or their **authorized representative's** receipt of an "adverse determination" or "final adverse determination."
- iv. The **covered person** or their **authorized representative** must complete an authorization form allowing **us** to disclose the **covered person's** protected health information, including medical records that are pertinent to the external review.
- v. The Commissioner will send a copy of the request for external review to **us** for a preliminary review within 1 business day of receipt. Within 5 business days of **our** receipt, **we** will complete the preliminary review to determine whether the request is complete and eligible for external review. Within 1 business day of **our** determination, **we** will notify the Commissioner and the **covered person** of **our** decision and, if not, the reasoning. A determination of an ineligibility can be appealed to the Commissioner.
- vi. Within 1 business day of receiving notice that a request is complete and eligible for review, the Commissioner will assign an IRO and notify the parties. The **covered person** will have 5 business days from receipt of this notice to provide any additional information to the IRO for consideration. **We** will provide the IRO with the documentation for the "adverse determination" or "final adverse determination" within 5 business days of receipt of this notice.
- vii. The IRO will forward any additional information to **us** that may be submitted by the **covered person** for **our** consideration.

viii. Within 45 calendar days of receipt of the request for external review, the IRO will issue written notice of its decision to uphold, reverse, or partially uphold **our** "adverse determination" or "final adverse determination."

b. Expedited External Review Procedures

The **covered person** has a right to request an expedited external review of an "adverse determination" or "final adverse determination" by an Independent Review Organization (IRO) approved by the Arkansas Insurance Commissioner.

i. Following receipt of an "adverse determination" a request for an expedited external review may be filed with the Commissioner at the same time the **covered person** or their **authorized representative** files a request for an expedited internal **grievance** review with **us** if:

- (1) the **covered person** has a medical condition where the timeframe to complete an internal expedited **grievance** review would seriously jeopardized the life or health of the **covered person** or would jeopardize the **covered person's** ability to regain maximum function; or
- (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 the **covered person's** treating **physician** certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.
- (3) the IRO conducting the external review will determine whether the **covered person** or their **authorized representative** will be required to complete **our** internal expedited **grievance** review prior to the IRO conducting the external review.

ii. Following receipt of a "final adverse determination" a request for an expedited external review may be filed if:

- (1) the **covered person** has a medical condition where the timeframe to complete an internal expedited **grievance** review would seriously jeopardize the life or health of the **covered person** or would jeopardize the **covered person's** ability to regain maximum function; or
- (2) the "final adverse determination" concerns an admission, availability of care, continued stay or health care service for which the **covered person** received emergency services, but has not been discharged from a facility; or
- (3) the "final 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 the **covered person's** treating **physician** certifies in writing and supports such certification reasoning, rationale, or evidence that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

iii. To request an expedited external review, the **covered person** and/or the **authorized representative** must send a written or electronic request for external review to the Commissioner at the following address:

Arkansas Insurance Commissioner
1200 West 3rd Street
Little Rock, AR 72201
1-800-282-9134

iv. Expedited external review must be requested at the time the **covered person** or their **authorized representative** receives an "adverse determination" or "final adverse determination" and include any additional or supporting documentation.

v. The **covered person** or their **authorized representative** must complete an authorization form allowing **us** to disclose the **covered person's** protected health information, including medical records that are pertinent to the external review.

vi. The Commissioner will send a copy of the request for external review to **us** for a preliminary review immediately upon receipt. **We** will immediately complete the preliminary review to determine whether the request is eligible for expedited external review and notify the Commissioner and the **covered person** of **our** decision. A determination of ineligibility can be appealed to the Commissioner.

- vii. Immediately upon receipt of a notice that a request is eligible for review, the Commissioner will assign an IRO and notify **us**. Upon receipt **we** will provide the documents and information relied upon to make the "adverse determination" or "final adverse determination" to the IRO.
- viii. As expeditiously as the **covered person's** medical condition or circumstances requires but in no event more than 72 hours after receipt of the request for expedited external review, or not more than 8 calendar days after receipt of the request for expedited review of **experimental or investigational** treatment, the IRO will issue written notice of its decision to uphold, reverse, or partially uphold **our** "adverse determination" or "final adverse determination."

c. For the purposes of this section:

i. "Adverse determination"

(1) means a determination by **us** or **our** utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered **benefit** has been reviewed and, based on the information provided, does not meet **our** requirements for **medical necessity**, appropriateness, health care setting, level of care or effectiveness, and the requested payment for the service is denied, reduced or terminated.

(2) Must be a "final adverse determination" unless an exception applies such as the failure to receive a timely decision from **us** or the criteria for an expedited external review are met.

ii. "Final adverse determination" means an "adverse determination" involving a covered **benefit** that has been upheld by **us** at the completion of **our** internal **grievance** procedure.

6. RECORDKEEPING

We will maintain a record of all **grievances** filed and their resolution. The record will include the name of the **covered person**, date of the **grievance**, nature of the **grievance**, date of response/resolution and summary of the resolution. Copies of all **grievances**, investigative material and response letters will be kept with the **grievance** record. The **grievance** record will be maintained in the claims office for a minimum of 5 years.

Periodically, **we** will review the **grievance** record. This review will include analysis of the appropriateness of responses.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Flesch Score Certification.pdf	Approved-Closed	12/13/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: The application was approved on 09/06/2011 under State Tracking # 49633.	Approved-Closed	12/13/2011

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: NA Comments:	Approved-Closed	12/13/2011



121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED MUTUAL INSURANCE COMPANY

READABILITY CERTIFICATION

for the state of
ARKANSAS

GH 03 10 (01-12 ed.)
GH 03 11 (01-12 ed.)

To the best of my knowledge and belief, these forms meet the Flesch minimum reading ease score of the Arkansas readability requirements with a combined score of 50.41.

A handwritten signature in black ink that reads "J. Hankerson".

Digitally signed by Jeanne Hankerson
Date: 2011.12.09 08:38:33 -06'00'

Jeanne H. Hankerson

First Vice President

December 9, 2011
