NOTICE OF GRIEVANCE PROCEDURES FOR INDIANA RESIDENTS

If You have questions about any decisions related to Your coverage with Trustmark Insurance Company (Trustmark), You may call Us and a Customer Service Representative will assist You.

LEVEL 1: Within 180 days from receipt of a claim decision, You, or Your personal representative may submit an oral or 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 continued stay;
- The availability of participating providers;
- The determination that a proposed service is not appropriate or medically necessary, or that a proposed service is experimental or investigational;
- Rescissions; or
- A determination concerning a prior authorization request.

If You feel Our determination on any of the above did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may file a grievance.

- We will, within 5 business days after receiving Your grievance, provide oral or written acknowledgment of the request.
- A decision will be made within 20 business days after receiving all the information necessary to complete the review.
- You will be informed of the grievance resolution, and Your right to appeal the decision, within five (5) business days after the investigation is completed.
- If We are unable to make a decision within that time frame due to circumstances beyond Our control, We will notify You, in writing and before 20th business day, of the reason for delay. You will then receive a written decision regarding the grievance and Your right to appeal the decision within additional 10 business days.

Written requests should contain the issues and comments which are pertinent and should be sent or faxed to:

Trustmark Insurance Company
Grievance Review Board
8324 South Avenue
Boardman, OH 44512
Fax (330) 965-7599

Or You may call Trustmark Insurance Company at 1-800-366-6663 for information or to make a formal grievance request.

LEVEL 2-GRIEVANCE APPEAL: If You feel Our determination did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may, within 60 days from receipt of the initial grievance review decision, request another appeal.

- We will, within 5 business days after receiving Your Grievance Appeal request, provide oral or written acknowledgment of the appeal. At that time We will inform You of the date on which a panel will meet to discuss Your appeal and of Your right to appear in person, or, if You are unable to appear, how to otherwise communicate with the panel, for Grievance Appeals regarding medical necessity or experimental or investigational procedures.
- A decision will be made within 45 days after receiving Your Grievance Appeal request.
- You will be informed of the Grievance Appeal resolution within five (5) business days after the investigation is completed.
- If We deny Your claim for medical services at the Grievance Appeal level, We will advise You that Our decision is a Final Adverse Decision and advise You of Your right to request an External Review by an

independent review organization, or to obtain additional information, at the address or phone number listed above.

LEVEL 3-EXTERNAL REVIEW: If You feel that Our determination of a Final Adverse Decision did not comply with the terms of Your policy/certificate, You, or Your personal representative, on Your behalf, may file a written request for an External Grievance Review not more than 120 days after You are notified of the Grievance Appeal determination concerning any of the following:

- An adverse determination of appropriateness,
- An adverse determination of medical necessity,
- Rescissions, or
- A determination that a proposed service is experimental or investigational, made by Us or one of Our agents regarding a service proposed by Your treating health care provider.

We will provide an expedited External Grievance Review for a grievance related to an illness, disease, condition, injury or a disability if the time frame for a standard review would seriously jeopardize Your life, health or Your ability to reach and maintain maximum function. We will provide a Standard Grievance Review for all other grievances.

- A decision will be made and You will be notified within 72 hours after an Expedited External Grievance is filed.
- A decision will be made within 15 business days after a Standard External Grievance is filed and You will be notified within 72 hours after the determination is made.

You will not be required to pay any costs associated with the services of an independent review organization. We are responsible for all associated costs. We will select the independent review organization from the list on the Indiana Department of Insurance website (IRO Rotation Assignments List). The selection process will be done sequentially without repeating until the entire list has been selected.

You may only file one external grievance review request per Grievance Appeal resolution. In addition, if You have the right to an external review by Medicare, You may not request an External Grievance Review under this process.

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204
Consumer Hotline: (800) 622-4461
www.in.gov/idoi