§ 4802. Grievance procedure. (a) An insurer which offers a managed care product shall establish and maintain a grievance procedure with regard to such managed care product. Pursuant to such procedure, insureds shall be entitled to seek a review of determinations by the insurer with regard to such managed care product, other than determinations subject to the provisions of article forty-nine of this chapter.

(b) (1) An insurer shall provide to all insureds written notice of the grievance procedure in the contract and at any time that the insurer denies access to a referral or determines that a requested benefit is not covered pursuant to the terms of the contract; provided, however, that nothing herein shall be deemed to require a health care provider to provide such notice. In the event that an insurer denies a service as an adverse determination as defined in article forty-nine of this chapter, the insurer shall inform the insured or the insured's designee of the appeal rights provided for in article forty-nine of this chapter.

(2) The notice to an insured describing the grievance process shall explain:

(i) the process for filing a grievance with the insurer;

(ii) the timeframes within which a grievance determination must be made; and

(iii) the right of an insured to designate a representative to file a grievance on behalf of the insured.

(3) The insurer shall assure that the grievance procedure is reasonably accessible to those who do not speak English.

(c) (1) The insurer may require an insured to file a grievance in writing, by letter or by a grievance form which shall be made available by the insurer, and which shall conform to applicable standards for readability.

(2) Notwithstanding the provisions of paragraph (1) of this subsection, an insured may submit an oral grievance in connection with (i) a denial of, or failure to pay for, a referral; or (ii) a determination as to whether a benefit is covered pursuant to the terms of the insured's contract. In connection with the submission of an oral grievance, an insurer may require that the insured sign a written acknowledgment of the grievance, prepared by the insurer summarizing the nature of the grievance. Such acknowledgment shall be mailed promptly to

the insured, who shall sign and return the acknowledgment, with any amendments, in order to initiate the grievance. The grievance acknowledgment shall prominently state that the insured must sign and return the acknowledgment to initiate the grievance. If an insurer does not require such a signed acknowledgment, an oral grievance shall be initiated at the time of the telephone call.

(3) Upon receipt of a grievance, the insurer shall provide notice specifying what information must be provided to the insurer in order to render a decision on the grievance.

(4) (i) An insurer shall designate personnel to accept the filing of an insured's grievance by toll-free telephone no less than forty hours per week during normal business hours and, shall have a telephone system available to take calls during other than normal business hours and shall respond to all such calls no less than one business day after the call was recorded.

(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, an insurer may, in the alternative, designate personnel to accept the filing of an insured's grievance by toll-free telephone no less than forty hours per week during normal business hours and, in the case of grievances subject to subparagraph (1) of subsection (d) of this section, on a twenty-four hour a day, seven day a week basis.

(d) Within fifteen business days of receipt of the grievance, the insurer shall provide written acknowledgment of the grievance, including the name, address and telephone number of the individual or department designated by the insurer to respond to the grievance. All grievances shall be resolved in an expeditious manner, and in any event, no more than:

(1) forty-eight hours after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health;

(2) thirty days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and

(3) forty-five days after the receipt of all necessary information in all other instances.

(e) The insurer shall designate one or more qualified personnel to review the grievance; provided further, that when the grievance pertains

to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals.

(f) The notice of a determination of the grievance shall be made in writing to the insured or to the insured's designee. In the case of a determination made in conformance with subparagraph (1) of subsection (d) of this section, notice shall be made by telephone directly to the insured with written notice to follow within three business days.

(g) The notice of a determination shall include:

(1) the detailed reasons for the determination;

(2) in cases where the determination has a clinical basis, the clinical rationale for the determination; and

(3) the procedures for the filing of an appeal of the determination, including a form for the filing of such an appeal.

(h) An insured or an insured's designee shall have not less than sixty business days after receipt of notice of the grievance determination to file a written appeal, which may be submitted by letter or by a form supplied by the insurer.

(i) Within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal, including the name, address and telephone number of the individual designated by the insurer to respond to the appeal and what additional information, if any, must be provided in order for the insurer to render a decision.

(j) The determination of an appeal on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination, at least one of whom must be a clinical peer reviewer as defined in article forty-nine of this chapter. The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

(k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than:

(1) two business days after the receipt of all necessary information when a delay would significantly increase the risk to an insured's health; and

(2) thirty business days after the receipt of all necessary

information in all other instances.

(l) The notice of a determination on an appeal shall include:

(1) the detailed reasons for the determination; and

(2) in cases where the determination has a clinical basis, the clinical rationale for the determination.

(m) An insurer shall not retaliate or take any discriminatory action against an insured because an insured has filed a grievance or appeal.

(n) An insurer shall maintain a file on each grievance and associated appeal, if any, that shall include the date the grievance was filed; a copy of the grievance, if any; the date of receipt of and a copy of the insured's acknowledgment of the grievance, if any; the determination made by the insurer including the date of the determination, and the titles and, in the case of a clinical determination, the credentials of the insurer's personnel who reviewed the grievance. If an insured files an appeal of the grievance, the file shall include the date and a copy of the insured's appeal, the determination made by the insurer including the date of the determination and the titles and, in the case of clinical determinations, the credentials of the insurer's personnel who reviewed the appeal.

(o) An insurer shall have procedures for obtaining an insured's, or insured's designee's, preference for receiving notifications, which shall be in accordance with applicable federal law and with guidance developed by the superintendent. Written and telephone notification to an insured or the insured's designee under this section may be provided by electronic means where the insured or the insured's designee has informed the insurer in advance of a preference to receive such notifications by electronic means. An insurer shall permit the insured and the insured's designee to change the preference at any time. The insurer shall retain documentation of preferred notification methods and present such records to the superintendent upon request.

(p) The rights and remedies conferred in this article upon insureds shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law.