Procedure for Appeals

Luther College Health Plan

An appeal (or internal appeal) is defined as review by a plan of an adverse benefit determination, as required under the plan's internal claims and appeals procedures.

The appeals level of the claims procedures is triggered by an “adverse benefit determination,” which is defined under the DOL claims procedure regulations as—

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan....

A claimant for purposes of the appeals regulations is an individual who makes a claim under the rules for internal claims and appeals and external review procedures, and expressly includes a claimant's authorized representative.

Adverse Benefit Determination

The Plan has 30 days from the date of the claim to issue a benefit decision. Please refer to the Summary Plan Description for timelines of extensions for different types of claims.

When a claimant receives notification of an Adverse Benefit Determination (via the Explanation of Benefits – EOB), the claimant has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision for a Post Service Claim. Please refer to the Summary Plan Description for timelines for Urgent Care and Pre-Service Claims.

All claims appeals should be initiated by filling out an Appeal Filing Form (found on the HR website). The claimant may submit written comments, documents, records and other information relating to the claim. If a claimant so requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Within 5 business days of receipt of the Appeal Filing, Luther’s HR Department will forward a copy of the appeal to Midwest Group Benefits, Inc. and request that they initiate the appeal process and notify the claimant in writing (or electronically) of the date the appeal was received.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review shall not afford deference to the initial benefit determination and shall be conducted by a fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor a subordinate of that individual.

If the determination was based on medical judgment, including determinations with regard to whether a particular treatment, drug, or other item Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. The health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts

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whose advice was obtained on behalf of the Plan in connection with the initial benefit determination will be identified.

Notice of Final Adverse Benefit Determination

A decision regarding the appeal shall be sent to the claimant within 60 days of date of receipt by the Plan. If the determination results in coverage for the service or item in the claim, the Plan will make payment and notify the claimant that the appeal has been resolved in their favor. The decision to uphold the denial of the claim will be summarized in the Notice of Final Internal Adverse Benefit Determination. The Notice of Final Internal Adverse Benefit Determination will include a list of all documents and statements that were reviewed to make this final internal adverse benefit determination.

Voluntary Appeal

A claimant may elect a voluntary appeal after exhaustion of appeals of a final adverse benefit determination. This voluntary appeal must be made within 30 days of notice of the final adverse benefit determination.

This voluntary appeal will be reviewed by the Appeals Committee at Luther College. The Committee will be comprised of three of the four following individuals: Vice President for Finance and Administration, Director of Human Resources, Director of Wellness and the Director of Student Health Service. The Committee will review all comments, documents, records and other information relating to the claim presented by the Plan and the claimant. Claimant has the right to their own legal representation and the decision of the Committee will have no effect on the claimant’s right to other benefits under the Plan.

The Committee, at its discretion may utilize an Independent Review Organization to evaluate the disputed claim. No fees or costs will be imposed on the claimant as part of the voluntary appeal. A decision of the Committee will be made within 30 days of the initial notice to the Committee and will be binding.

It is important to note that the appeals process is NOT intended to displace informal inquiries about claim determinations nor resolution of any errors or misinterpretations of claims that can be accomplished by direct communication between the claimant and the third party administrator. It is hoped that the formal claims process will occur only after such informal communications have occurred.

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