INSURANCE CLAIM COMPLAINT APPEAL PROCEDURE

Definition

A complaint may be made by an employee enrolled in the Illinois Central College Group Health Care Plan when there is an alleged misinterpretation or misapplication of the specific benefits provided by the Plan which cannot be resolved satisfactorily through regular claim channels.

Insurance Appeal Advisory Committee Purpose and Structure

A five-member Insurance Appeal Advisory Committee shall be designated to review complaints regarding claim denials and to make recommendations regarding the disposition of disputed claims alleging misinterpretation or misapplication of the specific benefits provided by the Illinois Central College Group Health Care Plan.

The Chairperson of the Committee shall be an administrator appointed annually by the President of the College. The four other members shall be selected from the current Insurance Committee membership and shall represent each of the following full-time employee categories: Faculty, Professional and Support Staff, Classified Staff and Service Staff.

If a Committee member feels he/she cannot perform impartially because of a conflict of interest, or the appearance thereof, in a particular case, he/she may ask to be replaced during the specific case. If the claimant feels a Committee member cannot serve impartially, he/she may request that such a member be excused from the Committee and a replacement be designated from the Insurance Committee membership.

Time Limits

Adequate time for completion of the activities prescribed within each step of this procedure is provided. However, the process should proceed as expeditiously as possible.

If a complaint is not filed within the time limits set forth, the claimant shall forfeit the right to challenge the insurance settlement in question; and the complaint shall not be processed further through the appeal procedure.

Time limits for each step in the procedure may be extended by mutual written agreement of the parties involved. The term “working days” shall mean the days Monday through Friday, inclusive, exclusive of holidays.

Procedure

Informal Complaint Resolution

Step 1: Questions and complaints regarding the initial settlement of an insurance claim shall be directed to Mutual Medical Plans, or the College’s designated third-party claim administrator, which will attempt to resolve misunderstandings or misapplication problems to the mutual satisfaction of all parties.

Step 2: If informal discussions with the Mutual Medical Plans representative do not resolve the problem, the claimant shall contact the College’s designated insurance administrator who, in turn, shall attempt to resolve the case. If the complaint is not resolved, the claimant may proceed to the formal appeal process.
Formal Complaint Resolution

Step 1: Within sixty (60) days after receipt of Mutual Medical Plans’ explanation of benefits worksheet summarizing the disposition of the insurance claim in question, the Plan enrollee, spouse or estate executor shall submit a completed copy of the Insurance Claim Complaint Form (Attachment A) to the College’s designated insurance administrator. The form shall contain:

a) the name of the claimant;
b) a concise statement describing the nature of the complaint;
c) a general explanation of the relevant facts which form the basis for the complaint, including copies of itemized bills, benefit explanations on which claims were denied and reasons the claimant feels there has been a misinterpretation or misapplication of specific benefits described in the Plan Description;
d) a statement about the resolution sought;
e) an account of any attempts made to resolve the problem through regular claim channels;
f) the signature of the claimant; and
g) the date on which the Complaint Form was submitted to the College’s insurance administrator.

Step 2: Within five (5) working days of receipt of the Complaint Form, the insurance administrator shall notify the Chairperson of the Insurance Appeal Advisory Committee about the complaint. The insurance administrator shall submit to the Committee Chairperson a copy of the claimant’s completed Complaint Form and supporting documentation together with a written rationale for the original disposition of the insurance claim.

Within five (5) working days, the Committee Chairperson shall distribute copies of these documents to Committee members for review. The Committee may request from either party further information which is deemed necessary, proper and/or relevant to the complaint.

Step 3: Within ten (10) working days of receipt of all related documentation, the Committee shall be convened and shall conduct other meetings as necessary in order to reach a decision, making every effort to complete its hearings within five (5) working days from the time it was convened. The Committee shall review the facts and issues presented to it in relation to specific benefits described in the College’s Health Care Plan Description and shall make a recommendation in writing to the President of the College regarding disposition of the complaint.

The Chairperson of the Committee shall submit the Committee’s findings and recommendations to the President within five (5) working days after completion of the Committee’s hearings of the complaint.

Step 4: Within fifteen (15) calendar days of receipt of the Committee’s recommendation, the President (or his/her designee), who may elect to endorse, reject or modify the recommendation, shall prepare and send a written explanation of the decision on the matter to the claimant, to the insurance administrator and to the Chairperson of the Insurance Appeal Advisory Committee. The decision of the President (or his/her designee) shall be final.