Health Market Conduct Annual Statement
Data Call & Definitions

Line of Business: Health

Reporting Period: January 1, 2022 through December 31, 2022

Filing Deadline: May 31, 2023

Contact Information

MCAS Administrator	The person responsible for assigning who may view and input company data.
MCAS Contact	The person most knowledgeable about the submitted MCAS data. This person can be the same as the MCAS Administrator.
MCAS Attestor	The person who attests to the completeness and accuracy of the MCAS data.

Schedule 1 - Interrogatories

1-01	In-exchange - Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report?	Yes/No
1-02	In-exchange - Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report?	Yes/No
1-03	In-exchange - Does the company have Catastrophic data to report?	Yes/No
1-04	In-exchange - Does the company have Multi-State (Individual) data to report?	Yes/No
1-05	In-exchange - Does the company have Multi-State (Small Group) data to report?	Yes/No
1-06	In-exchange - Number of small groups in-force at the end of the reporting period	
1-07	In-exchange - Does the company have an additional voluntary level of review for grievances?	Yes/No
1-08	In-exchange Comments	Comment
1-09	Out-of-exchange – Does the company have Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report?	Yes/No
1-10	Out-of-exchange – Does the company have Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report?	Yes/No
1-11	Out-of-exchange – Does the company have Grandfathered or Transitional plan data to report?	Yes/No
1-12	Out-of-exchange - Does the company have Catastrophic data to report?	Yes/No
1-13	Out-of-exchange – Does the company have Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report? (Y/N)	Yes/No

1-14	Out-of-exchange – Does the company have Student Coverage data to report? (Y/N)	Yes/No
1-15	Out-of-exchange - Number of small groups in-force at the end of the reporting period	
1-16	Out-of-exchange - Number of large groups in-force at the end of the reporting period	
1-17	Out-of-exchange - Does the company have an additional voluntary level of review for grievances? (Y/N)	Yes/No
1-18	Out-of-exchange Comments	Comment

Products

Product Identifiers	Explanation of Product Identifiers
IEIH	**In-exchange Individual Health insurance coverage other than transitional, grandfathered, or multi-state policies**
IESG	**In-exchange Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies**
IECA	**In-exchange Catastrophic**
IEMI	**In-exchange Multi-State – Individual**
IEMS	**In-exchange Multi-State – Small Group**
OEIH	**Out-of-exchange Individual Health insurance coverage other than transitional, grandfathered, multi-state, catastrophic or student**
OESG	**Out-of-exchange Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies**
OEGT	**Out-of-exchange Grandfathered/Transitional Plans**
OECA	**Out-of-exchange Catastrophic**
OELG	**Out-of-exchange Large Group comprehensive major medical and managed care (Minimum Essential Coverage) policies**
OESC	**Out-of-exchange Student Coverage**

Notes:

1) **The following products are reported by metal level (Bronze, Silver, Gold and Platinum): IEIH, IESG, IEMI, IEMS, OEIH and OESG except for questions designated with *. When designated with *, the products are reported in aggregate.**
2) **The OEGT product is reported with the following breakouts: Large Group, Small Group and Individual**
3) **Questions designated with + are not reported for the following products (Small Groups): IESG, IEMS, OESG and OEGT(Small Group Only).**

Schedule 2 - Policy Administration

2-19/92	Earned premiums for the reporting year
2-20-93	+Number of new policies issued during the period
2-21/94	+Number of policies renewed during the period
2-22/95	Member months for policies issued during the period
2-23/96	Member months for policies renewed during the period
2-24/97	+Number of policy terminations and cancellations initiated by the policyholder
2-25/98	+Number of policy terminations and cancellations due to non-payment of premium
2-26/99	Number of insured lives impacted on terminations and cancellations initiated by the policyholder
2-27/100	Number of insured lives impacted on policies terminated and cancelled due to non-payment
2-28/101	*Number of rescissions
2-29/102	Number of insured lives impacted by rescissions

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*
+ - These data elements are not reported for the following small group products: IESG, IEMS, OESG and OEGT (Small Group Only).

Schedule 2A – Prior Authorizations (Prospective Utilization Review Requests) – Excluding Pharmacy

2A-30/103	*Number of prior authorizations requested
2A-31/104	*Number of prior authorizations approved
2A-32/105	*Number of prior authorizations denied
2A-33/106	*Number of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.
2A-34/107	*Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied.
2A-35/108	*Number of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*

Schedule 2B – Prior Authorizations (Prospective Utilization Review Requests) – Pharmacy Only

2B-36/109	*Number of prior authorizations requested
2B-37/110	*Number of prior authorizations approved
2B-38/111	*Number of prior authorizations denied

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*

Schedule 3 – Claims Administration (Excluding Pharmacy)

3-39-112	Number of claims received
3-40/113	Number of claims submitted by network providers
3-41/114	Number of claims submitted by out of network providers
3-42/115	Number of claim denials for in-network claims
3-43/116	In-network claims denied within 0-30 days
3-44/117	In-network Claims denied within 31-60 days
3-45/118	In-network Claims denied within 61-90 days
3-46/119	In-network Claims denied beyond 90 days
3-47/120	Number of in-network denied, rejected or returned - Claims Submission Coding Error(s).
3-48/121	Number of in-network denied, rejected or returned - Prior Authorization Needed.
3-49/122	Number of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.
3-50/123	Number of in-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits.
3-51/124	Number of in-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).
3-52/125	Number of claim denials for out-of-network claims
3-53/126	Out-of-network claims denied within 0-30 days
3-54/127	Out-of-network Claims denied within 31-60 days
3-55/128	Out-of-network Claims denied within 61-90 days
3-56/129	Out-of-network Claims denied beyond 90 days
3-57/130	Number of out-of-network denied, rejected or returned - Claims Submission Coding Error(s).
3-58/131	Number of out-of-network denied, rejected or returned - Prior Authorization Needed
3-59/132	Number of out-of-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.

3-60/133	Number of out-of-network denied, rejected or returned - Not Medically Necessary (Excluding Behavioral Health Benefits
3-61/134	Number of out-of-network denied, rejected or returned - Not Medically Necessary (Behavioral Health Benefits Only).
3-62/135	Number of paid claims for in-network services
3-63/136	In-network claims paid within 0-30 days
3-64/137	In-network claims paid within 31-60 days
3-65/138	In-network claims paid within 61-90 days
3-66/139	In-network claims paid beyond 90 days
3-67/140	Number of paid claims for out-of-network services
3-68/141	Out-of-network claims paid within 0-30 days
3-69/142	Out-of-network claims paid within 31-60 days
3-70/143	Out-of-network claims paid within 61-90 days
3-71/144	Out-of-network claims paid beyond 90 days
3-72/145	Claims paid
3-73/146	Insured/beneficiary co-payment responsibility
3-74/147	Insured coinsurance responsibility
3-75/148	Insured deductible responsibility

Schedule 4 – Claims Administration (Pharmacy Only)

4-76/149	*Number of claims received
4-77/150	*Number of claim denials for in-network claims
4-78/151	*Number of claim denials for out-of-network claims
4-79/152	*Number of paid claims for in-network services
4-80/153	*Number of paid claims for out-of-network services
4-81/154	*Claims paid
4-82/155	*Insured/beneficiary co-payment responsibility
4-83/156	*Insured coinsurance responsibility
4-84/157	*Insured deductible responsibility

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*

Schedule 5 – Consumer Requested Internal Reviews (Grievances – Including Pharmacy)

5-85/158	Number of customer requests for internal reviews of grievances involving adverse determinations (Do not include additional voluntary levels of reviews.)
5-86/159	Number of adverse determinations upheld upon request for internal review (Do not include additional voluntary levels of reviews.)
5-87/160	Number of adverse determinations overturned upon request for internal review (Do not include additional voluntary levels of reviews.)
5-88/161	Number of customer requests for internal reviews of grievances not involving adverse determinations

Schedule 6 – Consumer Requested External Reviews (Including Pharmacy)

6-89/162	*Number of customer requested appeals on final adverse determinations to an external review organization
6-90/163	*Number of final adverse determinations upheld upon request for external review
6-91/164	*Number of final adverse determinations overturned upon request for external review

** - These data elements are not reported at the metal level. Instead they are reported in aggregate for the following products: IEIH, IESG, IEMI, IEMS, OEIH and OESG.*

Schedule 7—Health Attestation

By completing the attestation information, those named understand, agree and certify on behalf of the named company that:

1. They are authorized to submit the Market Conduct Annual Statement on behalf of the named company and to bind the company to the statements in this attestation;
2. They are knowledgeable of the information required to be provided in the Market Conduct Annual Statement filed by this company and have reviewed this filing;
3. To the best of their knowledge and belief, this filing represents a full and accurate statement of the information required to be provided in the Market Conduct Annual Statement pursuant to the applicable instructions; and
4. They are aware that the state insurance department(s) receiving the data may initiate regulatory action as authorized by law in a specific jurisdiction if the data submitted in the MCAS is inaccurate, incomplete, or found to be materially false, misleading or omissive.
5. They affirm that the company is able to accurately trace the data as reported to its source within the company and if necessary, recreate the MCAS results as reported in this filing.

NOTE: The company must provide the name for at least two individuals who are able to attest that the criteria listed above have been met, and attest to the overall accuracy of the MCAS filing. Both attestors should have participated in the review and validation of the filing. We recommend that one person be the individual with operational responsibility for the source data such as a responsible individual from claims, underwriting or compliance. We recommend that the second person should be a responsible IT person that participated in the creation of the data in the filing.

ID	Description
7-165	First Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-166	Second Attestor Information (First Name, Middle Name, Last Name, Suffix, Title)
7-167	Overall Comments for the Period

Participation Requirements: All companies licensed and reporting at least $50,000 of health earned premium for all coverages reportable in MCAS within any of the participating MCAS jurisdictions. (This threshold is subject to individual jurisdiction requirements.)

Report by Situs of Contract: The allocation of premium and claims between jurisdictions should be based upon situs of the contract. For purpose of this exhibit, situs of the contract is defined as "the jurisdiction in which the contract is issued or delivered as stated in the contract." For individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage. When the association is made up of employers, it should be reported as large group or small group depending on the size of each employer. For employer business issued through a group trust, the allocation shall be based on the location of each employer. For employer business issued through a multiple employer welfare association the allocation should be based on the location of each employer. (NAIC Annual Statement Instructions for the Supplemental Health Care Exhibit)

General Definitions:

Exchange (Marketplace) - The Affordable Care Act (ACA) creates new "American Health Benefit Exchanges" in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. An exchange may be a governmental agency or non-profit entity that meets the applicable standards of the ACA and makes Qualified Health Plans (QHPs) available on the marketplace to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a Small Business Health Options Program (SHOP) serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by Health and Human Services (HHS). The individual Exchange will determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them.

> **In-exchange –** Health insurance coverage acquired through the Exchange (marketplace) as described above.
>
> **Out-of-exchange –** Health insurance coverage acquired outside the Exchange (marketplace) as described above.

Health Insurance Coverage – Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. This is not intended to include excepted benefits as defined in 42 U.S.C. § 300gg-91(c). This is also not intended to include closed blocks not subject to Medical Loss Ratio (MLR) reporting under Centers for Medicare & Medicaid Services (CMS) guidance nor is it intended to include self-funded plans.

Metal Level (Bronze) – Health insurance coverage in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.

Metal Level (Silver) – Health insurance coverage in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.

Metal Level (Gold) – Health insurance coverage in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.

Metal Level (Platinum) – Health insurance coverage in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of

the full actuarial value (with allowable de minimus variations as described in 45 CFD 156.140(c)) of the benefits provided under the plan.

Catastrophic – Health insurance coverage that does not provide a metal level of coverage. Catastrophic coverage plans pay less than 60% of the total average cost of care and are available only to people who are under 30 years of age before the beginning of the plan year or who have received an exemption from the requirement to maintain minimum essential coverage by reason of hardship or lack of affordability.

Individual Health Insurance Coverage – Health insurance coverage offered in the individual market, but does not include short-term limited duration insurance.

Grandfathered Plan – Health insurance coverage that an individual was enrolled in prior to March 23, 2010 either through an individual health insurance coverage or group health insurance coverage plan. Grandfathered plans are exempted from most changes required by the ACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans. The plan may lose grandfathered status if significant changes are made to the plan.

Multi-State – Health insurance coverage created by ACA operated under contract with The U.S. Office of Personnel Management (OPM) and available in multiple states.

Small Group Health Insurance Coverage – Health insurance coverage offered in the small group market.

Student Coverage – Individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions: (1) Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education. (2) Does not condition eligibility for the health insurance coverage on any health status-related factor relating to a student (or a dependent of a student). (3) Meets any additional requirement that may be imposed under State law.

Transitional Plan – Plans that are issued pursuant to the policy promulgated by the Centers for Medicare & Medicaid Services (CMS) in a letter dated November 14, 2013 to the State Insurance Commissioners. If permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled or modified to comply with the ACA, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS has further stated that, under the transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2016 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met including the approval of state authorities.

Schedule 1 Definitions:

Rescission – A rescission is a cancellation or discontinuance of coverage that has retroactive effect due to fraudulent or material misrepresentation. (Does not include cancellations for non-payment.)

Earned Premium – Total premium earned from all policies written by the insurer during the specified period.

Number of policies issued – Number of policies for health insurance coverage issued during the specified period.

Number of policies renewed – Number of policies for health insurance coverage renewed during the specified period. If the policyholder number remains the same, count the policy as renewed.

Group Policy Clarifications:

- One group policy should be reported regardless of the number of products made available to the group.
- An insured group that changes products to another product offered by the same carrier should not be reported as a termination.t renewal, if a group changes to a new product with the same carrier this should be reported as a policy renewal (not as a policy issued).

Individual Policy Clarifications:

- An individual that changes policies to another policy offered by the same carrier should be reported as a termination.
- At renewal, if an individual changes to a new product with the same carrier this should be reported as a policy issued (not as a policy renewal).

Member months for policies issued – The *sum* of total number of lives insured on policies issued on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Member months for policies renewed – The *sum* of total number of lives insured on policies renewed on a pre-specified day of each month of the reported year. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity

Number of policy terminations and cancellations initiated by the policyholder– Number of policies terminated at the insured's request.

Number of policy terminations and cancellations due to non-payment of premium – Number of policies terminated because the insured never paid, or stopped paying, the required premium for coverage.

Number of insured lives impacted on terminations and cancellations initiated by the consumer – Total number of lives which were no longer covered as a result of policies terminated at the insured's request. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Number of insured lives impacted on policies terminated and cancelled due to non-payment – Total number of lives which were no longer covered as a result of policies terminated because the insured never paid, or stopped paying, the required premium for coverage. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Number of rescissions – Number of policies cancelled as a result of a rescission.

Number of insured lives impacted by rescissions – Total number of lives which were no longer covered as a result of rescissions. Reasonable approximations are allowed when exact information is not administratively available to the reporting entity.

Schedule 2 Definitions:

Prior Authorization – A decision by a carrier or its designee in advance of the provision of a health care service that the service (including specialist care, habilitation and rehabilitation services, and mental health and substance use disorder services), treatment plan, or medical device and equipment is medically necessary or a covered service. Sometimes called preauthorization, prior approval or precertification.

Behavioral Health Benefits – Benefits to assist those with mental health or substance abuse issues.

Mental Health Benefits – Benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Substance Use Disorders Benefits – Benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD), or State guidelines).

Prior Authorization Clarifications:

- A partially approved prior authorization should be reported as "approved".
- Prior authorization requests, approvals and denials should be reported according to the data year of the request, approval or denial.
- Prior authorizations reported as requested, approved and denied for mental health benefits, behavioral health benefits and substance use disorders should also be counted in the total reported prior authorizations. They are a subset of the total reported prior authorizations.

Schedules 3 and 4 Definitions:

Claim – For the purposes of this data call a claim means any individual line of service within a bill for services.

Claim Clarifications:

- Claims received, paid and denied should be reported according to the data year of the receipt, payment or denial.
- Claims are to be reported at the service line level.
- Capitated claims are to be reported if an Explanation of Benefits (EOB) is generated.
- Duplicate claims should not be reported.

Number of claims received – Number of claims received by a carrier during the period requesting payment or reimbursement based on the terms of the insurance policy. Note: For the purposes of this data call a claim means any individual line of service.

Denied Claims – The denial of a claim is the fully adjudicated decision by a carrier to not pay or reimburse a fully completed health care claim submitted for an insured or provider. A claim considered as eligible (e.g. applied to deductible or co-payment), but without a payment, is not a denied claim.

Clarification:

- The five claim denial reporting categories added for the 2018 data year are not exhaustive. Claim denials reported in the five categories should be a subset of the reported total denials.

Number of claims submitted by in-network providers – Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)). The provider agrees to the carriers' rules and fee schedules in order to be part of the network and usually agrees not to balance bill patients for amounts beyond the agreed upon fee. Note: For the purposes of this data call a claim means any individual line of service.

Number of claims submitted by out-of-network Providers – Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care

provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO). Note: For the purposes of this data call a claim means any individual line of service.

Number of claim denials for in-network claims – Number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as an HMO or PPO) and were subsequently denied by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Do not include claims that were pended for additional information and subsequently paid.

In-Network claims denial stratification of days – A grouping of number of days that it has taken to deny in-network claims. (0-30, 31-60, 61-90, 90+).

Number of claims denials for out-of-network claims – Total number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO) and subsequently denied by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Do not include claims that were pended for additional information and subsequently paid.

Out-of-network claims denial stratification of days – A grouping of number of days that it has taken to deny out-of-network claims. (0-30, 31-60, 61-90, 90+).

Number of paid claims for in-network services – Total number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for a carrier (such as an HMO or PPO) and were subsequently paid by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Include claims that were pended for additional information and subsequently paid.

In-network claims payment stratification of days – A grouping of number of days that it has taken to pay in-network claims. (0-30, 31-60, 61-90, 90+).

Number of paid claims for out-of-network services – Total number of claims received by a carrier asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of a carrier's network (such as an HMO or PPO) and subsequently paid by the carrier. Note: For the purposes of this data call a claim means any individual line of service. Include claims that were pended for additional information and subsequently paid.

Out-of-network claims payment stratification of days – A grouping of number of days that it has taken to pay out-of-network claims. (0-30, 31-60, 61-90, 90+).

Claims Paid – Total dollar value of payments by the carrier for benefits reflected in claimants' Explanations of Benefits (EOBs) for the requested period.

Insured/beneficiary co-payment responsibility – Total dollar value of co-payments reflected in claimants' EOBs for the requested period. A co-payment is a fixed amount (for example, $15) paid by a covered life for a covered health care service, usually paid when the service is provided. The amount can vary by the type of covered health care service.

Insured coinsurance responsibility – Total dollar value of co-insurance applied on benefits reflected in claimants' EOBs for the requested period. Co-insurance is the percentage amount, if any, of a covered benefit which the insured pays as share of the payment made against a claim.

Insured deductible responsibility – Total dollar value of deductibles applied by the carrier for the requested period. A deductible is the amount owed for health care services the plan covers before the health insurance or plan begins to pay.

Schedules 5 and 6 Definitions:

Adverse Determination – A rescission, or a denial, reduction, 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 member's, or eligible dependent's, eligibility to participate in a plan, and including a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

External Review – An independent review of an adverse determination or final adverse determination.

External (Independent) Review Organization – An entity that conducts independent external review of adverse determinations or final adverse determination.

Grievance – A written complaint, or oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination (appeal) made pursuant to utilization review; (2) Claims payment, handling or reimbursement for health care services; or (3) Matters pertaining to the contractual relationship between a covered person and a health carrier.

Grievance for Non-Adverse Determination – A grievance arising from any issue other than an adverse determination.

Internal Review – A process by which the insured may have an adverse determination reviewed by the carrier with respect to a denial of an admission, availability of care, continued stay or health care services for a covered person.

Overturned Decision – A reversal of a denial of an adverse determination by a health carrier or its designee utilization review organization.

Upheld Decision – A denial of an adverse determination that has been found to be supported by a health carrier or its designee utilization review organization.

Voluntary Review Level – A level of review beyond the normal internal appeals process.