



FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

Health Care Insurer Appeals Process Information Packet

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

"Grievance" means

- (1) a determination that a service or proposed service is not appropriate or medically necessary;
- (2) a determination that a service or proposed service is experimental or investigational;
- (3) the availability of participating providers;
- (4) the handling or payment of claims for health care services; or
- (5) matters pertaining to the contractual relationship between:
 - (a) you and your insurer; or
 - (b) a group policyholder and an insurer;

and for which you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

I. Levels of Review

You may ask your insurer to review its decisions involving your requests for service or your request to have your claims paid. You may file a grievance orally or in writing. In general, the following three levels will be available to you:

- | | |
|---------|--------------------------|
| Level 1 | Expedited Medical Review |
| Level 2 | Informal Reconsideration |
| Level 3 | Formal Appeal |
| Level 4 | External Review |

These levels of review are discussed more fully below.

A. Expedited Medical Review (Level 1)

1. Eligibility

a. Claim for a covered service not yet provided:

You may obtain Expedited Medical Review of your grievance for a covered service that has not already been provided if:

- * You have coverage with the insurer.
- * Your insurer has denied your request for a covered service.
- * Your physician or treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration process could cause a significant negative change in your medical condition.

b. Claim for a covered service already provided but not paid for:

You may not obtain expedited medical review of your denied request for a covered service that has already been provided. Instead, you may start the review process by seeking Formal Appeal (Level 3).

2. Decision:

After receiving the certification and the supporting documentation, the insurer has 24 hours to make a decision and orally communicate that decision to you or your health care provider. Written notice of the decision will also be mailed to you within one day after the decision has been orally communicated to you and/or your health care provider.

The written notice will include the criteria used, the clinical reasons for that decision and any references to supporting documentation. This notice will also be sent to your physician or treating provider.

a. Denial upheld

If your insurer agrees that the covered services should have been denied, you may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

B. Informal Reconsideration (Level 2)

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service that has not yet already been provided, and you do not qualify for an Expedited Medical Review (Level 1), you may ask for Informal Reconsideration (Level 2) of that denial by calling, writing or faxing your request to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

b. Claim for a covered service already provided, but not paid for:

You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal (Level 3)

2. Deadlines Applicable to the Informal Reconsideration Process:

You have up to two years after your insurer denies your request for a covered service to request an Informal Reconsideration.

Within five business days after receiving your request for Informal Reconsideration, your insurer will send you a notice showing that your request was received. At that time if the insurer does not have sufficient information to complete the Informal Reconsideration process the insurer will advise you that it may not proceed with its review unless additional information is provided. The insurer agrees to assist you in gathering the necessary information. You will also receive another copy of this information packet with that notice.

3. Decision

Your insurer has 20 days to make a decision and orally communicate that decision to you or your health care provider. If your insurer is unable to make a decision due to circumstances beyond its' control, the insurer will notify you in writing before the twentieth business day of the reason for the delay. The insurer must issue a written decision regarding the grievance within an additional ten business days. Written notice of the decision will also be mailed to you within 5 business days after the decision has been orally communicated to you and/or your health care provider. This notice will also be sent to your physician or treating provider. The notice will include the reasons for the decision, notice of your right to appeal at Level 3, Formal Appeal, and the name of a contact person.

a. Denial upheld

If your insurer continues to agree that the covered service should have been denied, you will receive a notice of that decision. The notice will include a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation.

You may ask for further review through the Formal Appeal process (Level 3) discussed below.

b. Denial reversed

If your insurer agrees that the covered service should have been provided, your insurer must authorize the service.

C. Formal Appeal (Level 3).

1. Eligibility

a. Claim for a covered service not yet provided:

If your insurer denies your request for a covered service after either the Expedited Medical Review (Level 1) or Informal Reconsideration (Level 2) you may send a written request for Formal Appeal within 60 days of the last denial to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

If you elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

b. Claim for a covered service already provided, but not paid for:

If your insurer denies your claim for a covered service that has already been provided, you may send written request for Formal Appeal within two years of the last denial to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

If you elect this option, you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

2. Deadlines Applicable to the Formal Appeal Process:

Within five business days after receiving your request for Formal Appeal, your insurer will send you a notice showing that your request was received. You will also receive another copy of this information packet with that notice.

a. Claim for covered service not yet provided:

Your insurer has 30 days to make a decision and mail a notice of that decision to you, send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

b. Claim for a covered service already provided, but not paid for:

Your insurer has 45 days to make a decision and mail a notice of that decision to you, send you the written decision and a description of the supporting documentation. Your insurer will also send a copy of this information to your physician or treating provider.

c. In the case of a grievance decision involving a determination that the service is not appropriate nor medically necessary or is experimental or investigational, your insurer will appoint a panel of one or more qualified individuals who:

- 1) have knowledge of the medical condition, procedure, or treatment at issue;
- 2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
- 3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and
- 4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

Your insurer shall allow you the opportunity to appear in person, or if unable to appear in person, otherwise appropriately communicate with the panel.

3. Decision

a. Denial upheld

If your insurer continues to agree that the covered service or claim for a covered service should have been denied, you will receive a notice of that decision within five business days after your insurer completes its investigation.

D. External Review (Level 4)

1. Eligibility

You may obtain External Review only after you have sought any available Expedited Medical Review (Level 1), Informal Reconsideration (Level 2), and Formal Appeal (Level 3), which are discussed above.

You or your representative must send your request for External Review in writing to:

{Fidelity Security Life Insurance Company}
{Technical Services Department}
{3130 Broadway, Kansas City, MO 64111}
{Phone: 800-648-8624}
{Fax: 816-968-0575}

2. Deadlines Applicable to the External Review Process

You have 120 days after you receive written notice from your insurer that your Formal Appeal has been denied to request External Review. All expenses associated with the external review process will be paid by your insurer.

3. External Review Process

Your insurer will select a different Independent Review Organization (IRO) for each external review requested from the list of IROs that are certified by the insurance department, and rotate the choice of an IRO among all certified IROs before repeating a selection.

An IRO shall

- (a) Make a determination to uphold or reverse your insurer's formal appeal decision and notify you within 72 hours after an expedited external grievance is filed, or,
- (b) Make a determination to uphold or reverse your insurer's formal appeal decision within 15 business days and notify you within 72 hours after making the determination.

4. Additional Information

If, at any time during the External Review, you submit additional information relevant to your insurer's decision under Formal Appeal (Level 3) that was not previously considered by your insurer then your insurer may reconsider its decision under Level 3, Formal Appeal, and the IRO will cease the External Review until the insurer's reconsideration is complete.

The insurer will notify you of a decision within 72 hours after the information is submitted for a reconsideration related to an illness, disease, condition, injury, or disability that would seriously jeopardize your:

- (a) life or health; or
- (b) ability to reach and maintain maximum function.

For a condition not described above, the insurer must notify you within 15 days after the information is submitted.

If the insurer's decision is adverse to you, you may request that the IRO resume the external review.

If the insurer chooses not to reconsider its' decision based upon the new information, the insurer will forward the information to the IRO not more than 2 business days after the insurer's receipt of the information.

II. Obtaining Medical Records

A. Requesting Medical Records

You have the right to ask for a copy of medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under any State Regulations remain confidential.

III. Documentation for an Appeal

If you decide to file an appeal, you must give the person who will be responsible for processing the appeal any material justification or documentation for the appeal at the time the appeal is filed. You must also give that person the address and phone number where you can be contacted.

IV. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other person.

V. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

VI. Indiana Department of Insurance website:

Information concerning the internal and external grievance procedures for accident and sickness insurance policies can also be found on the Indiana Department of Insurance's web site: <http://www.in.gov/doi/2547.htm>. You also have the right to contact the Indiana Department of Insurance by telephone at (317)-232-2385.