GRIEVANCE AND APPEALS PROCEDURE

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
P.O. Box 4884, Houston, TX 77210-4884 ● (281) 368-7200 or Toll-Free (800) 713-4680

Definitions

"Expedited grievance" means a grievance where any of the following applies:

(a) The duration of the standard resolution process will result in serious jeopardy to the life or health of the insured or the ability of the insured to regain maximum function.

(b) In the opinion of a physician with knowledge of the insured's medical condition, the insured is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

(c) A physician with knowledge of the insured's medical condition determines that the grievance shall be treated as an expedited grievance.

"Grievance" means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including any of the following:

(a) Provision of services.

(b) Determination to reform or rescind a policy.

(c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.

(d) Claims practices.

"Independent review" means a review conducted by a certified independent review organization.

"DOI complaint" means any complaint received by the office of the commissioner of insurance by, or on behalf of, an insured of an insurer offering coverage under a health benefit plan.

Grievance Procedure

(a) A grievance panel is available for the investigation of each grievance submitted under part (b), consisting of at least one individual authorized to take corrective action on the grievance and at least one insured other than the grievant, if an insured is available to serve on the grievance panel.

(b) You have the opportunity to appear in person before the grievance panel to present written or oral information. We will provide you 7 day written notice if We need to schedule any formal meeting to discuss your grievance.

(c) We will acknowledge the receipt of a grievance in writing within 5 business days of receipt.

(d) We will promptly investigate each grievance submitted under part (b).

(e) We will notify each grievant of the disposition of his or her grievance and of any corrective action taken on the grievance.

(f) We will retain records pertaining to each grievance for at least 3 years after the date of notification under part (e).

(g) If you elect to appear in person before the grievance panel as referenced in part (a) We will provide written notification to you of the time and place of the grievance meeting at least 7 calendar days before the meeting.

(h) If We are unable to resolve a grievance within 30 calendar days, the time period may be extended an additional 30 calendar days. In this situation We will provide a written notification to you of all of the following: (1) That We have not resolved the grievance. (2) When the resolution of the grievance may be expected and (3) The reason that additional time is needed.

(i) An expedited grievance will be made available when a non-expedited grievance would reasonably appear to seriously jeopardize your life or health or jeopardize your ability to regain maximum function. Such expedited appeal

will take place in consultation with a medical physician, and the decision will be communicated in writing to you and the provider as soon as your health condition requires but not later than 72 hours after receiving information justifying expedited grievance.

The Indiana Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at:

Indiana Department of Insurance
ATTN: Customer Services Division
311 w. Washington Street, Suite 300
Indianapolis, IN 46204-2787
https://www.in.gov/idoi/consumer-services/complaints/
Or by Telephone: (800) 622-4461 toll Free
Fax: (317) 234-2103

You may ask Us to review Our decisions involving your requests for service or your requests to have your claims paid. You may contact us at the following:

PO Box 4884
Houston, Texas 77210-4884
www.neweralife.com
Telephone: (800) 552-7879 Toll Free
(888) 748-3040 Claims

External, Independent Review

1. Eligibility

If We make a coverage denial determination you have the right to request an Independent Review after you have exhausted Internal Appeals with us. There are three categories of internal review which may apply:

a. Informal Reconsideration: This is the first-level review process that allows you to request a decision maker re-examine an adverse decision with or without a formal meeting or hearing. This is typically used to address corrections in the file, clarify existing information, provide new paperwork, etc.

b. Formal Appeal: This is a more structured, written request for Us to review the denial of a claim, service, or coverage. We have 30 days to make a decision on claims for a covered service that had not yet been provided or for claims for an unpaid covered service already provided for. We will send you a notice of our decision, along with clinical reasons for that decision and any references to supporting documentation. Your physician or treating provider may also receive a copy of this notice.

c. Expedited Medical Review: If you need immediate medical treatment and believe the time for resolving an internal grievance will jeopardize your life or health, you may ask to bypass the internal grievance process. Please submit your request and provide the necessary evidence so We may review and decide if your health condition requires this.

Appeals and Internal Review Requests can be made to the following:

Customer Service, Appeals Request
PO Box 4884
Houston, Texas 77210-4884
Email: appeals@neweralife.com
Customer Service: (800) 552-7879
Fax: (888) 748-3040 Claims

2. Procedures

If you wish to request Independent Review you or your authorized representative, must make this request within

4 months from the date of the coverage, denial determination, or from the date of your receipt of notice of the grievance panel decision, whichever is later.

You or your authorized representative may select an independent review organization from the list of certified independent review organizations, accompanying this notice, as compiled by the commissioner and available from the insurer.

Note: The Office of the Commissioner of Insurance maintains a current listing, revised at least quarterly, of certified independent review organizations and posts the current list on the office website: https://www.in.gov/idoi.

Your request for an independent review must be made in writing and contain the name of the selected independent review organization and should be addressed to

Claims Review Department
P.O. Box 4884
Houston, Texas 77210-4884
Toll Free: (800) 552-7879 Toll Free
Fax: (281) 368-7382

Please note that once the independent review organization makes a determination, the determination may be binding upon both Us and you. For pre-existing condition exclusion and rescission denial determinations, the independent review organization determination is not binding on the insured.

3. Waiver of requirements

You need not exhaust the internal grievance review procedures if either of the following conditions are met:

a. if We and you or your authorized representative agree that the appeal should proceed directly to independent review; or

b. the independent review organization determines that an expedited review is appropriate upon receiving a request from you or your representative that is simultaneously sent to Us.

4. Independent Review Timeframes

We will provide the all information required to the independent review organization without requiring a written release from you.

We will provide, upon written request from you or your authorized representative, a complete copy of your policy. We will respond to the written request within 72 hours of the request by mailing the copy to you or your authorized representative.

Information submitted to the independent review organization at the request of the independent review organization by either Us or you, will also be promptly provided to the other party to the review.

The above timeframes do not apply to situations where the independent review organization determines that the normal duration of the independent review process would jeopardize your life or health or your ability to regain maximum function. For these situations, the independent review organization shall develop a separate expedited review procedure for expedited situations that complies Indiana law and will be resolved as expeditiously as the insured's health condition requires.

5. Disputes

A dispute between you and Us regarding eligibility for independent review shall be considered a coverage denial determination and you may seek independent review of the determination in accordance with this section.

Disputes that are related to administrative matters, including enrollment eligibility, not related to treatment or services are not eligible for independent review determinations.