Utilization Review

1) **Telephone numbers** that the insured or provider can call, during normal business hours, for assistance obtaining mental or physical health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.
   - American National Insurance Company 1-800-899-6520
   - American National Life Insurance Company of Texas 1-800-899-6520
   - Garden State Life Insurance Company 1-844-639-3648
   - Standard Life and Accident 1-888-350-1488

2) **Prescription Coverage**: Our insured plans that provide prescription coverage do not utilize a drug formulary. This means that if your plan has prescription coverage, you may purchase any prescription FDA approved drug, provided it meets the medical necessity requirements of your plan. As an example, multivitamins are not covered.

   If your plan has a drug card, it utilizes the Express Scripts network. You can get more information by calling them at (800) 282-2881 or (800) 818-6630.

3) **Utilization Review**:

   Overview

   a) A utilization review determination will be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.
   b) The company will utilize written screening criteria that are evidence-based, scientifically valid, outcome-focused. The screening criteria will also recognize that if evidence-based medicine is not available for a particular health care service provided, the company will utilize generally accepted standards of medical practice recognized in the medical community.
   c) Adverse determinations will be referred and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.
   d) Our company may delegate some utilization review services to a NCQA or URAC accredited and state licensed URA. We will continue to maintain full responsibility for compliance state requirements, including the conduct of those to whom utilization review has been delegated.

   Detail

   Our screening criteria is available to the public upon request. We may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines to cover copying and postage costs. The disclosure will include the notice: "The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract."

If we request medical information from providers in order to determine whether to approve, modify, or deny a request for authorization, we will request only the information reasonably necessary to make the determination.

In determining whether to approve, modify, or deny requests prior to, retrospectively, or concurrent with the provision of health care services, based in whole or in part on medical necessity, we will meet the following requirements:

a) Decisions to review the medical necessity of proposed services by providers prior to, or concurrent with, the delivery of health care services shall be made in a timely fashion appropriate for the nature of the insured's condition, not to exceed 5 business days from our receipt of the information necessary to make the determination. In cases where the review is retrospective, we will communicate the decision to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is necessary to make this determination and shall be communicated to the provider in a manner that is consistent with current law.
b) When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours after we receive of the information reasonably necessary the insurer to make the determination.
c) We will communicate decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the insured in writing within 2 business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured's treating provider has been notified of the insurer's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
d) After a provider requests authorization of health care services, whether prior to, concurrent or retrospectively, we will communicate specifically what services were approved. If our decision is to deny, delay or modify the service, we will notify you in writing. We will notify the provider by telephone or fax, except that in the case of retrospective review, it will be in writing. . Our response will include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

   Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of California’s Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1.

e) If we are unable to meet the time requirements of California, we will keep you informed of the review’s progress. This may include outstanding information requested or referral to an outside consultant. In these situations, we will tell you the anticipated completion date.

4) PPO information

Our company has established a product that utilizes a Preferred Provider Organization (PPO) network to offer professional health care as needed. The principle of a PPO is to bring savings to you, the consumer, by providing a higher level of coverage (coinsurance) and reduced premiums, while directing business to providers. This benefits physicians and facilities in the PPO because they get potential patients, rather than needing to advertise to draw in business. For the insurance company, our expenses reduce, allowing us to reduce the member premiums.

Ultimately, the coverage is yours to utilize as you please. You are in the "driver's seat", steering the course of your medical care. You have the freedom to choose any medical provider in the network that is accepting new patients. You also have the ability to change medical providers to fit your need at any time. You only need go to the PPO's website address on your ID card or call them for a list of providers. Their toll-free number is also on your ID card. If you cannot locate your card, call us at 1-800-899-6520.

For PPO plans only: When it is an Emergency, or a PPO Provider is not Available

We know that sometimes no matter how hard you try, a PPO provider is not available and you will need to see an out-of-network, or nonpreferred provider. In these situations, you are still covered. In the following situations, we allow services as if performed by a PPO provider:

a) due to the emergency nature of the care;
b) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and when a nonpreferred provider's services were preauthorized based upon the unavailability of a preferred provider;
c) when the insured utilizes an in-network facility and the facility-related providers are not in-network (this applies to pathologist, radiologist, anesthesiologist, physical therapist, occupational therapist, respiratory therapist, or other physical medicine provider); or
d) when the insured has no choice in an assistant surgeon, if the surgeon is an in-network PPO provider.

In these situations, our company will pay a claim by a nonpreferred provider at the usual or customary charge for the service at the higher, preferred benefit coinsurance level, less any patient responsibility. Furthermore, when the insured provides documentation of payments made above and beyond the allowed amount, we will apply this amount to the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

Our company utilizes Fair Health, a nationally recognized vendor, to determine usual, reasonable, or customary charges. Fair Health employs generally accepted industry standards and practices for determining the customary billed charge for a service that fairly and accurately reflects market rates, including geographic differences in costs. Allowances are based on sufficient claim data to constitute a representative and statistically valid sample. Such data is updated twice per year and is no more than three years old. The methodology is consistent with nationally recognized and generally accepted bundling edits and logic.

5) Referrals, Discharge Planning and Continuity of Care

Your plan is not an HMO, where either a designated Primary Care Provider (PCP) carefully coordinates care, or you have no coverage. You have the freedom to use whichever provider you choose. Likewise, you have more responsibility for your care. Your plan does not require referrals from one provider to another; you are free to choose from any of the providers in your PPO network.

Your PPO ("preferred") provider has a responsibility to work with you through necessary changes.

- Referrals to another provider, such as specialists, for second opinions, etc.
- Discharging from a hospital, setting up rehabilitation services or home health care.
- It may be that a PPO provider will separate from a PPO network, whether because of retirement, relocation, or other reason.

When that happens, the provider has a contractual responsibility to help you transition to your next provider. In addition to these protections, we are only a toll-free number away.