STANDARD LIFE AND ACCIDENT INSURANCE COMPANY
(HEREIN REFERRED TO AS "THE COMPANY", "WE", "OUR" OR "US")
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

INTERNAL APPEAL AND EXTERNAL REVIEW PROCEDURES KENTUCKY

Internal Appeals

A Covered Person, the Covered Person's Authorized Representative, or a Provider acting on behalf of the Covered Person, may initiate an internal appeal with the Company. An appeal is a request for review of an Adverse Benefit Determination.

Adverse Benefit Determination (ABD) An adverse benefit determination (ABD) is a denial, reduction, termination or failure to provide or make payment (in whole or in part) for a benefit. There are different types of ABDs based on a determination that the benefit (i.e., service, treatment, drug or device) is:

- Not medically necessary.
- Experimental or investigational.
- Not covered or is excluded by the health plan.
- Reduced due to the Insured's failure to follow the plan delivery rules (e.g., insured did not obtain pre-authorization or did not use an in-network provider).
- Denied because the individual(s) is/are not eligible to participate in the plan.
- Denied due to a rescission of coverage (cancellation of coverage back to the effective date, leaving the Insured responsible for all medical bills, including those already paid by the Company) based on fraud or intentional misrepresentation.

Initiating an Appeal

A request for an internal appeal must be submitted within sixty (60) days of receipt of a denial letter and include: the initial denial letter, the number of claims in question, the date(s) of service, a summary of any previous communication the Covered Person has had with Us regarding the denial, and any pertinent medical information to:

Health Compliance
Standard Life and Accident Insurance Company
One Moody Plaza
Galveston, Texas 77550
Toll Free: 1-800-899-6510
Fax Number: 281-535-7150

Within thirty (30) days (seventy-two (72) hours for an expedited appeal) of receipt of the internal appeal request, We will send a written decision to the Covered Person or their authorized representative and, if applicable, the Covered Person's Provider.

An expedited appeal is deemed necessary when a Covered Person is hospitalized or, in the opinion of the treating physician, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

All claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the decision.

External Review

An external review of an ABD will be granted if the following criteria are met:

1. The Covered Person has completed the Company's internal appeal process, or the Company has failed to make a timely determination or notification, or the Company and the Covered Person have jointly agreed to waive the internal appeal requirement;
2. The Covered Person was covered by the health plan on the date of service or, if a prospective denial, the Covered Person was covered and eligible to receive covered benefits under the health plan on the date the proposed service was requested; and
3. The entire course of treatment or service will cost the Covered Person at least one hundred dollars ($100) if the Covered Person had no insurance.

An Independent Review Entity (IRE) will conduct the external review. The Covered Person must submit a request for external review to the Company within one hundred and twenty (120) days of receiving notice of the ABD.

The IRE will make its determination within twenty-one (21) calendar days from the receipt of all information required from the Company. An extension of up to fourteen (14) calendar days may be allowed if the Covered Person and the Company are in agreement.

External Expedited Review

An appeal will be considered an expedited appeal and can be conducted simultaneously with an internal appeal if at least one of these applies:

1. The Covered Person is hospitalized.
2. The Covered Person's treating physician determines it is urgent care.
3. The decision to deny coverage could seriously jeopardize the life, health or the ability to regain maximum function.
4. If in the opinion of the treating physician, who has knowledge of the Covered Person's medical condition, the Covered Person would be subjected to severe pain that cannot be adequately managed without the care that is the subject of the review.
5. The requested service is experimental or investigational and the physician certifies in writing that the service will be significantly less effective if not initiated promptly.

The IRE will make its decision within twenty-four (24) hours from the receipt of all information required from the Company. An extension of up to twenty-four (24) hours may be allowed if the Covered Person and the Company agree.

The IRE's decision is binding on the Covered Person and the Company. The IRE may bill the Covered Person a fee of $25, unless their decision is in the Covered Person's favor.

Benefit Determined as Limited or Excluded

If the denial is based on a benefit limitation or exclusion that is part of the Covered Person's health plan, the Covered Person may request an impartial review by the Health and Life Division of the Department of Insurance after completing the internal appeal process with the Company.

- Submit the request in writing to the Kentucky Department of Insurance, Health and Life Division, Attention: Coverage Denial Coordinator, P.O. Box 517, Frankfort, KY 40602.
- Enclose a copy of the denial letter from the health benefit plan.
- State the reason the Covered Person believes coverage should be provided.

The Coverage Denial Coordinator will request information from the Company and make a determination that the service, treatment, drug or device meets one of the following:

- Is specifically excluded under the plan and the Our denial was correct.
- Is covered and will instruct the Company to pay the claim.
- Requires the resolution of a medical issue and will instruct the Company to either cover the claim or give the Covered Person the opportunity to request an external review.

Plan delivery rules were not followed or other reason for receiving an ABD.

Plan delivery rules are requirements or specific procedures set forth in the health benefit document that must be followed to obtain maximum benefits (i.e., getting a pre-authorization, using an in-network provider). Other grievances can involve such events as the plan being canceled or rescinded.

If the ABD is a denial issued due to the Covered Person's failure to follow the plan delivery rules, or the Covered Person has a general complaint, the Covered Person may submit an appeal/complaint in writing to the Kentucky Department of Insurance, Consumer Protection Division, P.O. Box 517, Frankfort, KY 40602 or the Covered Person can fill out an online complaint form. State the reason(s) for appealing the ABD and submit copies of any documentation that supports the position.

Consumer Protection Division

If a Covered Person has any questions regarding any of these types of appeals, please contact the **Consumer Protection Division**:

Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
Internet: http://insurance.ky.gov/Home.aspx?Div_ID=4
Phone: **800-595-6053** (Kentucky residents only) or **502-564-6034**
(ask to speak to a Consumer Complaint Investigator)