

UTILIZATION REVIEW POLICIES AND PROCEDURES
ALLIED NATIONAL, INC.

Types of Utilization Review

Allied National, Inc. (Allied) does not pre-determine coverage or benefits. Coverage and benefits are determined only on a retrospective basis, after services have been provided and the claim has been submitted. However, to accommodate insureds and providers, prospective and concurrent utilization reviews (UR) are conducted upon receipt of pre-notifications for prospective or concurrent services. UR determinations for prospective, concurrent and retrospective review are handled according to the procedures below, with these differences

1). Prospective Reviews

Hospital Pre-notifications The provider of record is requested to provide all relevant information at least two (2) business days prior to the admission.

If the admission or service is required on an emergency basis, the call is requested within the first 48 hours or as soon as the insured or patient is able to provide insurance information to the provider. The provider of record is requested to then provide all relevant information within two (2) business days of the pre-notification call.

The admitting diagnosis, clinical information and treatment plan are evaluated by the Health Care Management (HCM) Registered Nurse (RN) using Milliman and Robertson (M&R) criteria, to confirm the appropriateness for hospitalization and the initial number of days for medical necessity. If a plan exclusion, ineligible expense or maximum benefit is identified, the same procedure is followed. This procedure is followed for all inpatient care, including medical, surgical and mental and substance abuse care.

Outpatient Pre-notifications Follows the same procedure as Hospital Pre-notification. Allied documents outpatient surgical and invasive procedures. Chiropractic care is not reviewed.

2). Concurrent Reviews

Discharge Pre-notifications On the scheduled discharge day, the hospital discharge unit or UR department is requested to contact Allied's HCM department to verify the patient has met M&R discharge criteria.

Extended Stay Pre-notifications Using M&R guidelines and professional judgment, the HCM RN evaluates the need for a longer hospital stay based upon clinical information provided by the hospital or attending physician. If the request for an extension does not meet M&R criteria, the provider is informed that future treatment does not meet medical necessity and may be denied by HCM or referred to an independent peer review consultant.

3). Retrospective Reviews

When Allied receives a claim for an inpatient hospitalization or outpatient procedure, after the services have been provided, a UR review of the admission or procedure is conducted on a retrospective basis. Unlike prospective and concurrent reviews, coverage and benefits are determined in retrospective UR reviews.

General Utilization Review Procedures

Requests for UR determinations based on pre-notifications are accepted by Allied from anyone authorized to receive the patient's personal health information under HIPAA, including the insured, patient, patient's family member, hospital or admitting physician's office.

Once a call is received requesting pre-notification of a proposed inpatient admission or outpatient procedure, the HCM RN will gather the clinical information necessary to make the UR determination, including medical necessity reviews. This information may be collected from the admitting physician or designee, hospital or in some instances the medical records. If all information needed to make the determination is not received after three (3) attempts, the HCM RN may determine that the pre-notification request has been withdrawn.

In medical necessity cases, the case may be forwarded to an independent peer reviewer for physician review. The peer reviewer will comply with these UR procedures and be Board Certified in the same or comparable discipline as the provider of record. Each independent peer reviewer is available a minimum of 40 hours each week (during normal business hours, Monday through Friday) and meets the requirements established for accreditation of UR programs by the UR Accreditation Commission (URAC).

The UR review will be completed within 72 hours of receipt of the request (or of all information needed to review the request). The attending physician or appropriate UR reviewer at the hospital is informed by telephone or fax within 24 hours of the UR determination, followed by a written UR determination mailed to the physician, the hospital (if appropriate) and insured (and his representative, if applicable).

All adverse determinations may be appealed (see below).

HCM Contact Information

Toll free number: 1-800-825-7531

Hours of Operation: 8:00 a.m. to 4:30 p.m. central time, Monday - Friday (except holidays).

Voicemail: 24 hours a day, seven (7) days a week. Messages are returned within one (1) business day.

Initial Screening Criteria

When pre-notification of outpatient or inpatient surgery or admission is received, the HCM RN will gather all clinical information necessary to conduct the UR review. This information may be collected from the admitting physician or designee, hospital, or in some instances, medical records, and will include, but is not limited to: diagnosis, severity of illness, current medical history, past medical history, physical or mental impairments, present treatment, diagnostic testing results, and co-morbidity.

The UR determination is based on the Optimal Recovery Guidelines, Adequate Reasons for Admission, and Surgical Authorization Guidelines by M&R. These guidelines are diagnosis and procedure specific, designed to evaluate clinical necessity for inpatient admissions and outpatient procedures, and appropriate use requires professional medical judgment. Physicians develop and periodically update the guidelines.

In addition to medical necessity guidelines, prescreening incorporates plan exclusion, ineligible expense and maximum benefit reviews.

These criteria are available for review upon request.

HCM Appeal & Grievance Procedures

Adverse determinations for prospective and concurrent UR reviews may first be appealed within the HCM, as explained below, then through the claims appeal process (see attached). Adverse determinations for retrospective UR reviews may be appealed only through the claims appeal process. A request for an HCM appeal must be in writing.

Appeals of adverse determinations based on medical necessity are forwarded by HCM to an independent peer reviewer not involved in the initial review. The HCM RN will gather any additional clinical information necessary to review the HCM appeal. The peer reviewer will review the information obtained by the HCM RN, or if insufficient, attempt to contact the admitting physician to obtain further information. The admitting physician will also have the opportunity to consult with the peer reviewer and share further information.

Appeals of adverse determinations based on plan language (i.e., plan exclusion, ineligible expense, maximum benefit, etc.) are reviewed by HCM staff (or other Allied staff) not involved in the initial review. The HCM RN reviews the information provided and will attempt to gather any additional information necessary for the HCM appeal.

Review of the HCM appeal will be completed within 72 hours of receipt of the appeal (or of all information needed to review the appeal). The attending physician or appropriate UR reviewer at the hospital is informed by telephone or fax within 24 hours of the appeal determination, followed by a written HCM appeal

determination mailed to the physician, the hospital (if appropriate) and insured (and his representative, if applicable).

If the adverse determination is upheld, the reason and any suggested alternative length of stay (or treatment setting) are provided and the determination may be appealed through the claims appeal process (see attached).

Grievances may be filed pursuant to the attached procedures.

HCM Staff

Allied's Physician Advisors ("PA's") are Board Certified licensed physicians in major medical specialties recognized by the American Board of Medical Specialists or the Advisory Board of Osteopathic Specialists and on staff with independent UR firms. The PA's are responsible for:

- Supervising and supporting the HCM staff, including the HCM RN.
- Reviewing HCM activities and approving adequacy of staff and resources.
- Reviewing and approving credentials of HCM staff.
- Reviewing and approving Allied's internal UR policies and procedures.
- Providing medical advice and information as needed to HCM.
- Reviewing adverse determinations processed by HCM.
- Consulting with attending physicians involved in UR cases processed by HCM.
- Reviewing appeals of UR adverse determinations processed by HCM.
- Providing all other medical review, advice, information, supervision, consultation and support as needed to HCM.

The HCM RN is a licensed RN responsible for clinical oversight of HCM. The HCM staff have previous experience in medical care environments and are trained in M&R Healthcare Management Guidelines.

Confidentiality

Access to computerized medical records and patient specific information is restricted to HCM and Claims Department staff and controlled by individual identification numbers and passwords. UR files are used solely for the purpose of providing expedient and thorough UR and claims payment and disclosed only to the extent reasonably necessary. All UR files are maintained and disclosed pursuant to HIPAA (and other applicable federal and state privacy and security regulations), then destroyed according to Allied's record retention policy. When contacting a provider regarding a UR matter, HCM staff provide their names and a separate Allied record tracking number for identification purposes. The exchange of HIPAA Personal Health Information (PHI) with providers occurs via secured and/or encrypted on-line communications. PHI is shredded and disposed of by a commercial company specializing in health insurance records.

NOTICE OF CLAIM PROCESSING PROCEDURES AND APPEAL RIGHTS

Your Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan established by your employer. As a Plan participant, you (and your covered dependant(s)) have certain claim processing and appeal rights under the Employee Retirement Income Security Act of 1974 (as amended) (ERISA) and state law.

1. INTRODUCTION

Introduction: Under ERISA and applicable U.S. Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described below are intended to comply with ERISA and these DOL regulations by providing reasonable procedures governing the filing of benefit claims, the issuing of benefit decisions and the reasonable notification of the right to appeal adverse benefit determinations.

Purpose: These procedures are furnished as a separate document that accompanies the Summary Plan Description (SPD) for your Plan. These procedures comply with ERISA and the DOL regulations. Consult the SPD for details regarding the benefits provided under the Plan.

2. DEFINITIONS

Plan: The Plan is the Employee Welfare Benefit Plan established by your employer.

Claim: A claim is any request for a Plan benefit or benefits made in accordance with these procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant: You become a claimant when you make a request for a Plan benefit or benefits in accordance with these procedures.

Incorrectly-Filed Claim: Any request for benefits that is not made in accordance with these procedures is called an incorrectly-filed claim.

Authorized Representative: An Authorized Representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized until the Plan receives written authorization signed by the claimant. Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding determinations, unless the claimant provides specific written direction otherwise. *Any reference in these procedures to claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.*

Plan Sponsor/Plan Administrator/Plan Fiduciary/Plan Trustee: Your employer is the Plan Sponsor, Plan Administrator and Plan Fiduciary for the Plan. Benefits under the Plan are funded by insurance contracts. Premiums for the insurance are paid for by employer and employee contributions. Your employer, in its capacity as the Plan Administrator and in light of the purposes for which the Plan was established and is maintained, shall consider and render, in its sole discretion, appropriate eligibility determinations. The insurance company shall consider and render, in its sole discretion, appropriate coverage and benefit determinations. In particular, the insurance company shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the Plan. The insurance company is also responsible for making claim and appeal determinations.

Designated Administrator: Your employer and the insurance company have, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, Inc., a licensed third-party administrator (Allied National). As the designated administrator, Allied National is authorized to process enrollments, bill and collect contributions, process claims payments, and perform other services, according to the terms of the agreement.

3. HOW TO FILE A CLAIM FOR BENEFITS

General Filing Rules: A claim for benefits is made when a claimant (or authorized representative) submits written Notice and Proof of Loss as required in the SPD to:

Allied National, Inc., Attn: Claims Department, PO Box 29186, Shawnee Mission, KS 66201 (fax: 913-9454390)

A claim will be treated as received by the Plan (a) on the date it is hand delivered to the above address; (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address (the postmark on any such envelope will be proof of date of mailing); (c) on the next business day immediately following the date it is faxed using the above fax number; or (d) on the next business day immediately following the date it is electronically submitted in compliance with HIPAA electronic transaction standards.

Notice of a claim shall be filed within 30 calendar days, and Proof of Loss of a claim shall be filed within 90 calendar days, following receipt of the medical service, treatment or product to which the claim relates. However, if it was not reasonably possible to file notice or proof within those time periods, notice must be filed within 90 calendar days, and Proof of Loss must be filed within six (6) months, following receipt of the medical service, treatment or product (except in the case of legal incapacity of the claimant).

How Incorrectly-Filed Claims Are Treated: These procedures do not apply to any request for benefits that is not made in accordance with these procedures.

4. DETERMINING BENEFITS

Timeframe: The Plan shall determine benefits for a claim, or request any additional information needed to process an incomplete claim, within a reasonable time, but no later than 30 calendar days after receipt of the claim. The Plan issues only retrospective (post-service) claim determinations.

When Extensions of Time Are Permitted: Nothing prevents the claimant from voluntarily agreeing to extend the above timeframe.

Incomplete Claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

How Incomplete Claims Are Treated: If a claim is incomplete, the Plan may deny the claim or request the missing information within the 30-calendar day timeframe described above. If the Plan requests the missing information, it shall do so in writing and include a description of the missing information. The missing information must be provided within 45 calendar days. If the missing information is provided, the Plan shall determine benefits within 15 calendar days of receipt. If the missing information is not provided within the 45 calendar days, benefits may be denied or the claim may be inactivated.

5. NOTIFICATION OF ADVERSE DETERMINATION BY PLAN

Written Notification: Written notification of an adverse determination by the Plan shall be provided to the claimant.

Content of Notification of Adverse Benefit Decision: Written notification provided to the claimant of the Plan's adverse determination on a claim shall include the following, in a manner calculated to be understood by the claimant:

- a statement of the specific reason(s) for the determination;
- reference(s) to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to complete the required proof of loss and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the determination; and
- if the determination involves scientific or clinical judgment, disclose an explanation and discussion of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances.

Definition of Adverse: A determination on a claim is "adverse" if it is a denial, reduction or 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 participant's or beneficiary's eligibility to participate in a plan.

6. YOUR RIGHT TO APPEAL

Your Right to Appeal: A claimant has a right to appeal an adverse determination and to receive a full and fair review under these procedures.

7. HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

Claim Inquiries: Please contact Allied National's Customer Service department at **1-800-825-7531** with any questions about the processing of your claim, including coverage and benefit determinations and Claim Reviews.

Internal Claim Review: If you disagree with a coverage or benefit determination, you have the **RIGHT TO APPEAL** that determination by requesting an Internal Claim Review within **180 CALENDAR DAYS** from the date you received the coverage or benefit determination. Only one (1) Internal Claim Review is available per claim. An Internal Claim Review determination acts as a Final Internal Adverse Benefit Determination.

Internal Claim Review Instructions and Procedures:

1. To request an Internal Claim Review, please
 - a. State your request for an Internal Claim Review in writing, include your full name, date of birth and certificate number, identify the claim in question, and explain why you disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.
 - b. Sign and date your written request and attach all supporting documentation.
 - c. Mail the written request and attachments to the following address, **within the 180-day deadline stated above:**
Allied National, Inc., Attn: Internal Claim Reviews, PO Box 29186, Shawnee Mission, KS 66201

1. Upon request and at no charge, you may have reasonable access (including copies) to the claim file, including all documents, records and information submitted to our office that relate to your claim.

2. The Internal Claim Review will take into account all written comments, documents, records and other information submitted to our office that relate to your claim, including comments, documents, records or other information not previously considered or submitted at the time the claim was processed.
3. Copies of any clinical rationale or review criteria and any new or additional evidence which the Internal Claim Review considers, relies upon or generates will be included with our written determination, free of charge.
4. The Internal Claim Review will be a “fresh” look at your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination, not currently supervised by someone involved in that determination, and whose terms of employment are not based on the likelihood of upholding that determination.
5. If the appealed determination is based on a medical judgment (in whole or in part), the Internal Claim Review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination, not currently supervised by someone involved in that determination and whose terms of employment are not based on the likelihood of upholding that determination.
6. You, your doctor or your authorized representative may request an Internal Claim Review and you may be represented by a relative, friend, lawyer or other authorized representative.
7. You may present evidence and testimony by submitting written comments, documents, records or other information relating to the claim. Hearings, panel reviews or other formal in-person proceedings are not conducted.
8. Within 5 business days of receiving your written request, our office will mail a written acknowledgement to you.
9. Within 30 calendar days of receiving your written request, our office will mail a written determination to you.

Optional Second Internal Review: If you disagree with the Internal Claim Review, you may go directly to External Review (if available, see below) or request an optional Second Internal Review. A written request for a Second Internal Review must be submitted to our office within 180 CALENDAR DAYS [six (6) months] from the date you received the determination for the initial Internal Claim Review. Please refer to the Internal Claim Review Instructions and Procedures stated above for completing and submitting a written request for a Second Internal Review. Only one (1) Second Internal Review is available per claim. A Second Internal Review is completely voluntary and not required to exhaust your rights of appeal under your health plan coverage.

External Review: You may have a right to External Review of your claim if:

1. You disagree with the Internal Claim Review (or the optional Second Internal Review, if one was requested); and
2. Your claim is eligible for Independent or External Review by an Independent Review Organization (IRO) under applicable law (including, but not limited to, medical judgment determinations such as medical necessity, appropriateness, health care setting, level of care or effectiveness).

Please refer to the External Review Instructions below for submitting a written request. Only one (1) External Review is available per claim. External Review is provided at no charge to you (some states may charge a small processing fee) and acts as a Final External Review Decision.

External Review Instructions: If External Review is available for your claim, an application packet will be enclosed with the determination for the Internal Claim Review. To request External Review, please follow the instructions contained in the packet and mail the application within 120 CALENDAR DAYS [four (4) months] from the date you received the determination for the Internal Claim Review (or the Second Internal Review, if one was requested).

State Assistance: You also have the right to request assistance from, or to file a complaint with, the Department of Insurance (DOI) or Consumer Services Division (CSD) for your state of residence (or employment), at any time. Please note the following contact information:

CA: CSD, 980 9th St., S. 500, Sacramento, CA 95814, <http://www.healthhelp.ca.gov>, 888-466-2219, helpline@dmhc.ca.gov

CO: DOI, 1560 Broadway, S. 850, Denver, CO 80202, <http://www.dora.state.co.us/insurance>, 800-930-3745

GA: CSD, 2 MLK, Jr. Dr., W. Tr., S. 716, Atlanta, GA 30334, <http://www.oci.ga.gov/consumerservice/home.aspx>, 800-656-2298

IL: CSD, 320 W. Washington St., 4th Fl., Springfield, IL 62727, <http://www.insurance.illinois.gov>, 877-527-9431

IN: DOI, 311 W. Washington St., S. 300, Indianapolis, IN 46204-2787, <http://www.in.gov/idoi>, 800-622-4461

IA: CSD, 330 Maple St., Des Moines, IA 50319, <http://www.insuranceca.iowa.gov>, 877-955-1212

KS: CSD, 420 SW 9th St., Topeka, KS 66612, <http://www.ksinsurance.org>, 800-432-2484, CAP@ksinsurance.org

MO: CSD, 301 W. High St., Rm. 830, Jefferson City, MO 65101, www.insurance.mo.gov, 800-726-7390

NE: DOI, 941 O St., S. 400, Lincoln, NE 68508-3639, <http://www.doi.ne.gov/>, 877-564-7323

NV: CSD, 555 E. Washington Ave., S. 4800, Las Vegas, NV 89101, <http://www.govcha.state.nv.us>, 888-333-1597

OH: DOI, 50 W. Town St., 3rd Fl., S. 300, Columbus, OH 43215, <http://www.ohioinsurance.gov/>, 800-686-1526

OK: CSD, 3625 NW 56th St, S 100, OK City, OK 73112, <http://oid.ok.gov/>, 800-522-0071

PA: CSD, 1326 Strawberry Square, Harrisburg, PA 17111, www.insurance.pa.gov, 877-881-6388

TN: CSD, 500 James Robertson Pkwy, DC Tr, 4th Fl, Nashville, TN 37243, www.tn.gov/commerce/insurance, 800-342-4029

TX: CSD, MC 111-1A, 333 Guadalupe, Austin, TX 78714, www.texashealthoptions.com, 855-839-2427, chap@tdi.state.tx.us

VA: CSD, P.O. Box 1157, Richmond, VA 23218, <http://www.scc.virginia.gov/boi>, 877-310-6560

Plan Assistance: To request assistance from or file a complaint with the Plan, please note the following contact information:

Allied National, Inc., P.O. Box 29186, Shawnee Mission, KS 66201, <http://www.alliednational.com/>, 800-825-7531

Judicial Review: If you exhaust all administrative rights of appeal under your Group Health Plan, you have the right to bring a civil action under Section 502(a) of ERISA. The time limitations stated in your Plan SPD for bringing legal actions or proceedings apply to any such civil action.

NOTICE OF RIGHT TO AN INDEPENDENT MEDICAL REVIEW

This NOTICE contains important information about your insurance claim and your **RIGHT TO SEEK INDEPENDENT MEDICAL REVIEW** of the coverage or benefit determination. Please carefully read the following instructions on how to request an **Independent Medical Review**, pursuant to California law. If you have any questions about submitting your written request, please call our Customer Service department **C/O Allied National, Inc.** at [**1-800-825-7531**].

IMPORTANT: You must submit your request within the **time period** explained below.

Independent Medical Review Process

A. Eligibility

You may apply to the Independent Medical Review System if:

- You are a resident of California;
- Benefits have been denied, modified or delayed (in whole or in part) for any health care service, due to a finding that the service is not Medically Necessary ("Disputed Health Care Service");
- The denial of benefits is not substantially based on a finding that provision of the health care services is excluded from coverage under the terms and conditions of the policy ("Coverage Decision");
- You have completed the Grievance Review process and you contest the determination (or your grievance remains unresolved and it was submitted more than 30 days ago); and
- It has been no more than 6 months since you received the Grievance Review determination (or, if your grievance remains unresolved, no more than 6 months and 30 days since you submitted the grievance). The Commissioner of the California Department of Insurance may extend the application deadline if warranted by circumstances.

B. Application and Fees

If you are eligible to obtain an Independent Medical Review, you may apply by completing the application form and using the addressed envelope enclosed with the Grievance Review determination, or by mailing a written request to either the:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles CA 90013
800-927-HELP (in CA)
213- 897-8921 (outside CA)**

or the following address (upon receipt, the request will be forwarded to the California Department of Insurance):

**Claims Department
ATTN: Independent Medical Reviews
GUARANTEE TRUST LIFE INSURANCE COMPANY
C/O Allied National, Inc.
PO Box 29186
Shawnee Mission, KS 66201-9186**

There are no application or review fees or charges for you to pay.

C. Review Procedures

The California Department of Insurance will, at the time of the receipt of the request for an Independent Medical Review, assign an Independent Medical Review Organization (IMRO) from the list of certified IMROs and will so inform the insurer.

If the request for an Independent Medical Review is not based on a Disputed Health Care Service, but on a Coverage Decision, the California Department of Insurance will instead conduct the review. If there is ambiguity as to what entity should conduct the review, the review will be conducted by an IMRO.

Within 3 business days after the date on which the insurer receives notice of the IMRO from the California Department of Insurance, the insurer will provide to the assigned IMRO all documents and information utilized in making the Disputed Health Care Service, as well as the final written decision from the insurer, including:

- A copy of all of your medical records in the possession of the insurer relevant to your medical condition, the health care services being provided for that condition, and the Disputed Health Care Services.
- Any newly developed or discovered relevant medical records in the possession of the insurer after the initial documents are provided to the IMRO shall be forwarded immediately to the IMRO independent medical review, with copies forwarded to you (or your provider, if authorized by you), unless declined or otherwise prohibited by law.
- A copy of all information provided to you by the insurer concerning insurer and provider decisions regarding your condition and care, and a copy of any materials you or your provider submitted to the insurer in support of your request for the Disputed Health Care Services. This documentation shall include the Grievance Review determination.
- A copy of any other relevant documents or information used by the insurer in determining whether the Disputed Health Care Services should have been provided, and any statements by the insurer explaining the reasons for the decision to deny benefits for the Disputed Health Care Services on the basis of Medical Necessity, with copies forwarded to you (or your provider, if authorized by you), unless declined, prohibited by law, or the Commissioner of the California Department of Insurance determines it to be legally privileged information.

The California Department of Insurance and the IMRO shall maintain the confidentiality of any information found by the Commissioner to be proprietary information of the insurer and the confidentiality of all your medical record information shall be maintained pursuant to applicable state and federal laws.

D. Confidentiality

Your medical records provided to the insurer and the IMRO and the findings and recommendations of the IMRO are confidential and will be used only by the California Department of Insurance, the IMRO, and the insurer. The medical records and findings and determinations will not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate and will not be included under any materials available to public inspection.

The insurer may at any time determine to provide the requested medical services by so notifying the IMRO or the California Department of Insurance, and you. Such notification will terminate the Independent Medical Review process.

NOTICE OF GRIEVANCE RIGHTS AND PROCEDURES

Claim Inquiries: Please contact our Customer Service department C/O Allied National, Inc. at [1-800-825-7531] with any questions about the processing of your claim, including coverage and benefit determinations and Grievance Reviews.

Grievance Reviews: If you disagree with a coverage or benefit determination, you have the **RIGHT TO FILE A GRIEVANCE** about that determination within **180 CALENDAR DAYS** from the date you received the coverage or benefit determination.

Grievance Review Instructions and Procedures:

10. To submit a grievance, please
 - a. State your request for a Grievance Review in writing, include your full name, date of birth and certificate number, identify the claim in question, and explain why you disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.
 - b. Sign and date your written request and attach all supporting documentation.
 - c. Mail the written request and attachments to the following address, **within the 180-day deadline stated above: Claims Dept, Attn: Grievance Reviews, Guarantee Trust Life Insurance Company, C/O Allied National, Inc., PO Box 29186, Shawnee Mission, KS 66201-9186.**

2. Upon request and at no charge, you may have reasonable access (including copies) to all documents, records and information submitted to our office that relates to your claim, including clinical rationale or review criteria.
3. The Grievance Review will take into account all written comments, documents, records and other information submitted to our office that relate to your claim, including such comments, documents, records or other information not previously considered or not submitted at the time the claim was processed.
4. The Grievance Review will be a “fresh” look at your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination and not supervised by someone involved in that determination.
5. If the appealed determination is based on a medical judgment (in whole or in part), the Grievance Review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination and not supervised by someone involved in that determination.
6. You or your doctor may request a Grievance Review, and you may be represented by a relative, friend or lawyer.
7. Within 5 business days of receiving your written request, our office will mail a written acknowledgement to you.
8. Within 30 calendar days of receiving your written request, our office will mail a written determination to you.

Additional Grievance Review Available:

1. If you disagree with the Grievance Review determination, you may voluntarily request a second Grievance Review. To exercise this second and final RIGHT TO FILE A GRIEVANCE, you must submit another written request for a Grievance Review to our office within 180 CALENDAR DAYS from the date you received the determination for the first Grievance Review. Please refer to the Grievance Review Instructions and Procedures stated above for completing and submitting a written request for a second Grievance Review. NOTE: A SECOND GRIEVANCE REVIEW IS COMPLETELY VOLUNTARY AND IS NOT NECESSARY IN ORDER TO EXHAUST ALL ADMINISTRATIVE RIGHTS OF APPEAL UNDER THE POLICY OR TO REQUEST AN INDEPENDENT MEDICAL REVIEW.
2. If you disagree with any Grievance Review determination (first or second), you have a right under California state law to request an Independent Medical Review of your claim. Our office will mail written notice of that right (see below) on or before our receipt of your initial request for a Grievance Review, and an application form will be enclosed with each Grievance Review determination. Strict time limits within which to request an Independent Medical Review apply.

State Assistance:

You have the right to request assistance from, or to file a complaint with, the California Department of Insurance at any time. Please note the following contact information: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles CA 90013, 800-927-HELP (in CA), 213- 897-8921 (outside CA)].

Judicial Review:

If you disagree with a Grievance Review determination, you have the right to bring a civil action under California state law (if benefits have been denied based on Medical Necessity, you must first exhaust all rights to an Independent Medical Review under California state law). The time limitations stated in your Certificate of Insurance for bringing legal actions or proceedings apply to any such civil action.