



FIDELITY SECURITY LIFE INSURANCE COMPANY®

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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.

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. In general, the following three levels will be available to you:

- Level 1 Expedited Medical Review.
- Level 2 Informal Reconsideration.
- Level 3 Formal Appeal.

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 denied request 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:

Allied National, LLC
Attn: Claims Department
PO Box 29186, Shawnee Mission, KS 66201
Phone: 800-825-7531
Fax: 913-945-4399

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 two 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

Unless you or your health care provider agree in writing to an extension of up to 30 business days, your insurer has 30 days 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 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.

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:

Allied National, LLC
Attn: Claims Department
PO Box 29186, Shawnee Mission, KS 66201
Phone: 800-825-7531
Fax: 913-945-4399

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:

Allied National, LLC
Attn: Claims Department
PO Box 29186, Shawnee Mission, KS 66201
Phone: 800-825-7531
Fax: 913-945-4399

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 60 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.

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.

b. Denial reversed

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

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.