NOTICE OF APPEAL RIGHTS TO CONNECTICUT RESIDENTS

In response to Health Care Reform, Connecticut Public Act 11-58 gives You the right under specific circumstances to apply for an External Review for the denial, reduction, termination or failure to make payment under Your health benefit plan on the basis that:

1. The benefit does not meet Our requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service, or
2. We considered the drug, procedure or therapy to be experimental and/or investigational; or
3. We have made an Adverse Determination involving eligibility to participate in the health benefit plan; or
4. We have rescinded coverage due to an alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact.

As used in this notice, the terms “You” and “Yours” means the insured or covered person. The terms “We”, “Us” and “Our” refer to 4 Ever Life Insurance Company (4EL).

No covered person who exercises the right to file a Grievance or Appeal shall be subject to disenrollment or otherwise penalized due to the filing of a grievance or appeal.

All complaint procedures are voluntary and at any time, You, Your health care provider or Your authorized representative, may seek the assistance of the Commissioner of Insurance, by writing to or calling at the following address:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford, CT 06142-0816

or

(FOR OVERNIGHT MAIL ONLY)

Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

Phone: (860) 297-3910
Email: externalreview@ct.gov
Web site: www.ct.gov/cid

Level 1: Internal Review (Grievance)

If a claim is denied either in whole or in part, You, Your treating physician or authorized representative, may file a Grievance either orally (by telephone or in person) or in writing within 180 days of receiving a denial in Your claim.

If Your claim was denied due to missing or incomplete information, You, Your treating physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

You, Your treating physician or authorized representative, have the right to complain about any decision We make that denies payment on the claim for coverage of a health care service or treatment.

You, Your treating physician or authorized representative, may request more explanation when Your claim for coverage of a health care service or treatment is denied or was not fully covered.

In case of an initial Adverse Determination that was based in whole or in part on medical necessity of a concurrent utilization review, we may offer Your treating physician the opportunity to confer with a clinical peer provided You have not filed a grievance of such initial Adverse Determination prior to such conference. Such conference shall not be considered a Grievance of such initial Adverse Determination.

In the case of a Concurrent review request, a determination shall be made within a reasonable time appropriate to our medical condition, but not later than 15 calendar days after the date We receive such request, and You will be notified of such determination. In the case of a Grievance involving a concurrent review request, the treatment shall be continued without liability to You until You have been notified of the review decision.

Contact us when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Cannot find the applicable provision in Your Benefit Plan Document; or
- Disagree with the denial or the amount not covered and You want to appeal.

Your request should contain an explanation of all pertinent issues. To contact Us, You may:

- Send an email to: bcsassist@bcsins.com
- Call Us by dialing Our toll free number at: (800) 621-9215
- Write Us at the following address:

  4 Ever Life Insurance Company
  Attn: Appeal Request
  2 Mid America Plaza, Suite 200
  Oakbrook Terrace, IL 60181-4712

If Your claim was denied due to missing or incomplete information, You, treating physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

Within 5 business days of receipt of Your request, You will receive a letter from Us confirming the receipt of Your grievance with the name, address and telephone number of the person who will be reviewing Your grievance. If all required information is complete, Your grievance will be resolved within 30 days of receipt. If additional information is required, We will send You a letter requesting the information. Your grievance will then be resolved within 20 days of receipt of all requested information.

Level 2: Internal Review (Appeal):

If Your grievance was denied for the following reasons:

- Services are deemed not medically necessary;
- Services are no longer needed in that health care setting or level of care;
- The effectiveness of the health care services has not been proven; and
- Services are considered experimental/investigational for treatment of this condition..

You, Your treating physician or authorized representative, have the right to appeal Our determination within 180 days of Your receipt of notice of Our Adverse Decision. The denial letter from Us will give You very specific information on how to file an appeal.

If You choose to file an appeal, it is important that You follow the appeals instructions in Your denial letter and act within the designated timeframes. If You do not file Your appeal within these timeframes, You lose Your rights to future review of the Adverse decision.

Adverse Decision means a determination by Us or a designee review agency, that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment rendered and the payment for the service is therefore denied, reduced or terminated.

You may submit any comments, documents, records or other information You, Your treating physician or authorized representative, may contact Us by:

- Sending an email to: bcsassist@bcsins.com
- Calling Us at Our toll free number: (800) 621-9215
- Writing Us at the following address:

  4 Ever Life Insurance Company
  Attn: Grievance/Appeal Request
  2 Mid America Plaza, Suite 200
  Oakbrook Terrace, IL 60181-4712

We will provide a fair and full review of Your claim by individuals associated with Us but who were not involved in making the initial denial of Your claim. Your appeal will also be reviewed by a clinical reviewer who is a physician or health care professional in the same or similar specialty as typically manages Your medical condition, procedure or treatment. For appeals of certain behavioral health services, Your appeal will also be reviewed by a reviewer with a specified board certification in a relevant specialty to the requested services.

You, Your treating physician or authorized representative, may provide Us with additional information that relates to Your claim without regard to whether those materials were considered in the initial grievance review. To assist You in the appeal, You may request free of charge reasonable access to and copies of all documents, records or other information that We have relevant to Your claim.

You have the right to assistance in filing Your appeal from the following state agencies:

Department of Insurance
Division of Consumer Affairs
153 Market Street
P.O. Box 816
Hartford, CT 06142-0816
Direct – 1-800-297-3900
Toll Free – 1-800-203-3447
Fax – (860) 203-3447
Email: cid.ca@ct.gov
Web Address: www.ct.gov/cid

OR

Office of Healthcare Advocate (OHA)
153 Market Street
Hartford, CT 06144
Tel No. 1-866-466-4446
Fax: (860) 297-3992
Email: Healthcare.advocate@ct.gov

We will notify You, Your treating physician or authorized representative of Our decision in writing within 30 calendar days of receiving Your request for standard appeals, 72 hours for urgent or expedited requests and 24 hour turnaround for Mental Health and Substance Abuse. If You do not receive Our decision within the stated turnaround times of receiving Your request for an appeal, You, Your treating physician or authorized representative, may be entitled to immediately file a request for independent external review. Notice of final Adverse Determination on a standard appeal shall be deemed to have been received by You or Your authorized representative five (5) calendar days after the notice is mailed.

Please Note: If the services are denied because they are not a covered benefit under Your plan, or Your benefits for this service have reached their limit, or then the grievance process is concluded after Your final internal appeal and no further appeal or review is allowed under the

plan. Whenever We fail to strictly adhere to the requirements with respect to receiving and resolving grievances involving an adverse determination, You shall be deemed to have exhausted the internal grievance process and may file a request for an external review.

Expedited Internal Review:

Unless You, Your authorized representative has failed to provide information necessary for Us to make a determination of an urgent care request, a determination shall be made as soon as possible taking into consideration Your medical condition, but not later than 24 hours after receipt of such request.

Under the Connecticut External Review Program, You may apply for an expedited external review of the denial of medical services when it is determined that the time frame for completion of an expedited internal appeal of the denial of services may seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function. This expedited external review is available immediately following the initial Adverse Determination or following any level of Adverse Determination on internal appeal. You do not have to exhaust Our internal appeals process before applying.

To qualify for an expedited appeal, You must have Your physician complete the Physician Certification Form attached to the "Request for External Review" application.

However, Appeals for services already provided will not be considered for an expedited external review.

Please Note: An expedited external review may be filed at the same time as an expedited internal review, except that the Independent Review Organization will determine whether You shall be required to complete the expedited internal review prior to conducting the expedited external review.

Independent External Review:

Once the internal grievance process is exhausted through Us, You may request an independent review through the Connecticut External Review Program. The External Review process was set up in the State of Connecticut to mediate disputes regarding the Medical Necessity of a covered benefit or service, including experimental and/or investigational services, and other disputes involving eligibility and rescission of coverage.

The Connecticut Insurance Department contracts with Independent Review Organizations (IRO) to perform medical reviews of the denied services, as well as reviews of other eligible grievances. Based on their impartial review, the IRO determines whether the medical services are Medically Necessary and should be approved, or if the eligibility or rescission determination by Us should be reversed. The decision of the IRO is independent of Our determination and the State of Connecticut Insurance Department, and the decision is binding.

To be eligible for the external review process through the State of Connecticut Insurance Department, you must satisfy the following requirements:

► **You must have exhausted the internal appeal process of your health plan.**

We will provide You with written notification that You have exhausted the internal appeal process. This requirement is waived for expedited external reviews. You have the right to file an expedited external review immediately following any Adverse Decision or following any Adverse Decision on internal appeal.

► You must file your External Review within 120 days.

Your completed “Request for External Review” must be filed with the Insurance Department within 120 days of receiving the written notification that the internal appeals have been exhausted.

For expedited appeals, You may file immediately after the initial Adverse Decision or following any Adverse Decision on internal appeal

► You must be actively enrolled in Your health care plan at the time the service was requested or when the service is provided.

► The External Review is for a service or procedure that is covered in Your contract.
You may only use this external review process to appeal for services that are covered in Your contract. The review process cannot be used to expand the coverage of Your contract. For example, this process cannot be used to authorize coverages that are exclusions in Your contract. Be sure to review the listed exclusions in Your contract.

► The denial of medical treatment or services must be based on certain criteria.

To qualify for External Review the denial of medical treatment or services must be based on medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service, experimental and or/investigational determination, or must involve an Adverse Decision involving eligibility to participate in the health benefit plan, or a rescission of health coverage.

► The group or individual medical policy must be written in the State of Connecticut.

► Your insurance health benefit plan must be a fully insured plan to be eligible.

“Self-insured” plans are not included in the Connecticut External Review Program. Your employer can tell you if Your plan is “self-insured” and direct You to any grievance options available under Your plan.

EXTERNAL REVIEW FILING PROCEDURES:

You, or Your provider with Your written consent, may request an external review. The "Request for External Review" application and all supporting documents for the external review must be filed with the Insurance Department within 120 days of receiving the final denial letter.

The following items must be included in your application, as your review will be rejected if all of these items are not included:

» Application - Completed “Request for External Review” application

» ID Card - Copy of the patient's insurance identification card

» Final Denial Letter - Copy of the final denial letter received from Us denying Your request at the final level of their internal appeals process. (For Expedited External Reviews attach the last denial letter received.)

» Filing Fee - Check or money order for $25 made payable to "Treasurer, State of Connecticut" or a Request for Waiver of the Filing Fee*

The filing fee will be waived by the Insurance Commissioner for indigent individuals or those individuals who are unable to pay the $25 fee. Indigent individual means an individual whose adjusted gross income (AGI) for the individual and spouse from the most recent federal tax return filed, is less than two hundred percent of the federal tax poverty level. In addition, the filing fee is waived for any covered person who has already paid the maximum fee of $75 per calendar year

Waiver of Filing Fee Guidelines

. **# of Family Members**	**200% of 2011 Federal Poverty Level**
1	$21,780
2	$29,420
3	$37,060
4	$44,700
5	$52,340
6	$59,980
7	$67,620
8	$75,260 *

» Physician Certification Form Required for:

- Expedited External Review - Request for review of Experimental/Investigational Denials

» Any New Medical Information (Optional) - It is Your responsibility to provide any additional new medical information that You wish to have considered as part of the external review.

Please Note: All medical records submitted during the internal appeal process will be forwarded automatically by Us to the IRO reviewing Your case.

The Insurance Department contracts with IRO's to review external review requests. Once Your completed application is received, the Insurance Commissioner will send Your request to Us to conduct a Preliminary Review to determine if You meet the eligibility requirements for external review described in the "Eligibility for External Review" portion of this notice. If We determine that You do not meet the eligibility requirements for external review, We will notify You of their decision in writing. If You disagree with this determination, You may file an appeal with the Insurance Commissioner who will make the final decision on eligibility.

If Your application for External Review is accepted, the Insurance Commissioner will immediately assign an IRO to conduct a full review. The IRO is required to notify all parties of their decision within the following time frames:

Standard External Review – 45 Days
Experimental and/or Investigational Review – 20 Days

Expedited Review – 72 hours
Expedited Experimental and/or Investigational Review – 5 Days

The IRO will make one of the following decisions:

Affirm the denial of services (accept the denial)
Reverse the denial of the services (overturn the denial)
Revise the denial of the services (partially overturn the denial)

You will be notified directly by the IRO of their decision and a copy of these findings will be shared with Us, Insurance Commissioner and Your authorized representative, if applicable.

If Your appeal results in a "reverse" or "revise" determination, We will be responsible for reprocessing your claim according to the terms and conditions of Your plan. In addition, the Insurance Department will refund the $25 application fee when a "reverse" or "revise" determination has been rendered.

All decisions of the IRO are final and the decision is binding. This means that if the IRO decides in Your favor, then We are required to approve the benefit or services that were previously denied. There is no provision for the further appeal of this decision.

Expedited External Review

Expedited external review requests are conducted when your provider certifies that:

- Standard timeframes for processing of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or
- Your treating physician feels that you woujld experience severe pain that cannot be adequately managed without these services; or
- If you are seeking services related to a substance use disorder or a co-occurring mental disorder, your request will automatically be handled as an expedited external review. For services related to a mental disorder, Your request will be expedited for the following services: Inpatient service, partial hospitalization, residential treatment or intensive outpatient service necessary to avoid an inpatient setting.

NOTE: Expedited External Reviews are not available when services have already been rendered.

Reconsideration of Our Decision:

If, at any time during the review process, You, Your treating physician or authorized representative, submits information to Us relevant to Our resolution of Your request for review and for which We had not originally considered, We may reconsider our determination.

If Your request has already been submitted for independent external review and We choose to reconsider Our decision, the independent review organization will suspend its review process until Our reconsideration process is completed. In such case, We will notify You of Our decision within 15 days of receiving the new information.

If we decide not to reconsider Our determination upon review of the new information, We will forward that new information to the independent review organization not more than 2 business days of receiving it.