

## NOTICE OF GRIEVANCE PROCEDURES

If You are aggrieved by a claim decision of Guarantee Trust Life Insurance Company up to 4 levels of appeals may be pursued. Levels I, II, and III form the Internal Grievance Review process conducted by Us. The Level IV appeal is the Ohio External Review process. This Ohio External Review process is available for appeals regarding a denial of coverage due to lack of medical necessity and may be used after the completion of the internal appeal process.

**LEVEL 1:** You may request an appeal of an action or decision of within 90 days of the event giving rise to the appeal. The appeal request should be submitted in writing to Us at the address and telephone number listed on Your coverage identification card. The request for an appeal should include:

- a statement that this is a request for an appeal;
- the name and relationship of the person making the appeal;
- the reason for the appeal;
- any information that might help resolve the issue;
- the date of the service or claim; and
- if possible, a copy of the Explanation of Benefits.

We will review all materials, make a decision, and respond to You in writing within 30 days of receipt of the completed information needed to respond to the appeal.

**LEVEL 2:** If you are dissatisfied with the results of the Level 1 review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a 2<sup>nd</sup> Level Grievance Review within 90 days of receiving the Level 1 decision.

The request for an appeal should include:

- a statement that this is a request for a Level 2 appeal and the date of the Level 1 determination;
- the name and relationship of the person making the appeal;
- the reason for the Level 2 appeal, including any substantive additional information not previously submitted

A decision will be made by a Supervisor within 30 calendar days after receiving your second level Grievance Review request. We will advise You of Our decision.

**Level 3:** If you are dissatisfied with the results of the Level 2 review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a 3<sup>rd</sup> level Grievance Review within 90 days of receiving the Level 2 decision.

The request for an appeal should include:

- a statement that this is a request for a Level 3 appeal and the date of the Level 2 determination;
- the name and relationship of the person making the appeal;
- the reason for the Level 3 appeal, including any substantive additional information not previously submitted

A decision will be made by a Claim Manager and/or Vice-President of Claims within 30 calendar days after receiving your second level Grievance Review request. We will advise You of Our final decision.

### **Administrator Contact Information:**

You may submit Your appeal request for formal Grievance Review to the following address:

Ms. Tina Tobias  
Manager, Claims Department  
Guarantee Trust Life Insurance Company  
1275 Milwaukee Avenue  
Glenview, IL 60025  
800-338-7452

## OHIO EXTERNAL REVIEW

### GENERAL EXTERNAL REVIEW

You or Your authorized representative may request an external review of a coverage denial if both of the following are the case:

- We have denied, reduced, or terminated coverage for what would be a covered health care service except that We have determined that the health care service is not medically necessary.
- Except in the case of an expedited review, the proposed service, plus any ancillary services and follow-up care, will cost You more than five hundred dollars (\$500) if the proposed service is not covered by Us.

If You have a terminal condition, We will follow the External Review for Experimental or Investigative Treatment procedures detailed in such section of these Procedures.

A request for a General External Review will not be granted in any of the following circumstances:

- You have failed to exhaust Our internal review process.
- You have previously been afforded an external review for the same denial of coverage, and no new clinical information has been submitted to Us.

We will deny a request for a General External Review if it is requested later than 60 days after notice has been sent regarding a final determination of the internal appeal process. A General External Review may be requested by You, an authorized person, Your provider, or a health care facility rendering health care service to You. You may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without Your prior consent.

A General External Review must be requested in writing, except that if You have a condition that requires Expedited Review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us not later than 5 days after the request is made.

A request for a General External Review must be accompanied by written certification from Your provider or the health care facility rendering the health care service to You that the proposed service, plus any ancillary services and follow-up care, will cost You more than \$500 dollars if the proposed service is not covered.

Except in the case of an expedited review, the independent review organization will issue a written decision not later than 30 days after the filing of the request. The independent review organization will send a copy of its decision to Us and to You. If Your provider or the health care facility rendering health care services to You requested the review, the independent review organization will also send a copy of its decision to Your provider or the health care facility.

We will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of the insured's policy or certificate.

### EXTERNAL REVIEW OF DENIAL OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT FOR TERMINAL CONDITIONS

You or Your authorized representative may request an external review of a coverage denial if all of the following are the case:

- You have a terminal condition that, according to the current diagnosis of Your physician, has a high probability of causing death within 2 years.
- You request a review not later than 60 days after notice from Us regarding a final determination of the internal appeal process.
- Your physician certifies that You have a terminal condition as described above and any of the following situations are applicable:
  - Standard therapies have not been effective in improving Your condition.
  - Standard therapies are not medically appropriate for You.
  - There is no standard therapy covered by Us that is more beneficial than therapy recommended by your physician.

- Your physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to You, in the physician's opinion, than standard therapies, or You have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
- You have been denied coverage by Us for a drug, device, procedure, or other therapy recommended or requested, and has exhausted Our internal review process.
- The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for Our determination that the drug, device, procedure, or other therapy is experimental or investigational.

A review must be requested in writing, except that if Your physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us not later than 5 days after the oral or written request is submitted.

When You meet the criteria set forth above You have the opportunity to have Our decision to deny coverage reviewed under this Process. You will be notified of that opportunity within 30 business days after We deny coverage.

Except in the case of an expedited review, the independent review organization will issue a written decision not later than 30 days after the filing of the request. The independent review organization will send a copy of its decision to Us and to You. If Your provider or the health care facility rendering health care services to You requested the review, the independent review organization will also send a copy of its decision to Your provider or the health care facility.

The independent review organization will provide Us with the opinions of a panel of up to 3 experts. We will make the experts' opinions available to You and Your physician, upon request.

The opinion of the majority of the experts on the panel is binding on Us with respect to You. We will provide any coverage determined by the independent review organization's decision to be Medically Necessary, subject to the terms, limitations, and conditions of Your policy or certificate. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, Our final decision will be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, We may, in Our discretion, cover the therapy.

If Our initial denial of coverage for a therapy recommended or requested is based upon an external, independent review of that therapy meeting the requirements as stated above, this review process shall not be a basis for requiring a second external, independent review of the recommended or requested therapy.

At any time during the external, independent review process, We may elect to cover the recommended or requested health care service and terminate the review. We will notify You and all other parties involved by mail or, with consent or approval, by electronic means.

## **EXPEDITED REVIEW**

For an expedited review, Your provider must certify that Your condition could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of You or, with respect to a pregnant woman, the health of the unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

The independent review organization will issue a written decision not later than seven days after the filing of the request for an Expedited Review.