UTAH GRIEVANCE AND APPEALS PROCEDURE

GENERAL INFORMATION

If you do not agree with the payment or denial of a claim, you and your health care provider have the right to appeal the claim decision. When appealing a claim, you and your health care provider should state all of the facts as to why you believe the claim should be reconsidered and provide any additional supporting documentation. If we require any specific forms, such as a written authorization of representation or a medical records release consent form, such forms will be provided to you within five (5) calendar days of receipt of your request for appeal.

You may contact Ameritas Life Insurance Corp. at:

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free)

If we deny a claim or render an adverse decision, we will include in our notice of an adverse determination or coverage denial, information regarding our internal appeal process. "Coverage denial" means that we have made a determination that a service, treatment, drug or device is specifically limited or excluded under your insurance plan. "Adverse determination" means we have determined that a health care service or treatment furnished or proposed to be furnished to a covered person is: 1) not medically necessary; 2) experimental; or 3) investigational, and we have denied, reduced or terminated coverage. In addition to stating the reason for the coverage denial or adverse determination, the notice will contain instructions for filing a request for an internal appeal review. Additionally, the notice will also include information regarding an external review process that you, your authorized representative, or a health care provider acting on your behalf and with your consent may request upon receipt of the adverse determination or coverage denial.

Internal Appeal Process

You, your authorized representative or a health care provider acting on your behalf and with your consent, have the right to request an internal appeal review within sixty (60) days after receipt of the adverse decision or coverage denial. We will provide the decision to you, your authorized representative and a health care provider on internal appeals of adverse decisions or coverage denials within thirty (30) days of receipt of the request for an internal appeal review.

The internal appeal review will be conducted by a licensed health care provider who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, and upon your request, we will utilize a board eligible or certified health care provider in the appropriate specialty or subspecialty to conduct the internal review.

The internal appeal process will include review and consideration of those portions of your or the covered person's medical records that are relevant to the internal appeal, with your authorization and in accordance with state or federal law. You and a health care provider will be given the opportunity to present additional information.

We will provide our decision to you, your authorized representative and your health care provider within thirty (30) days of receipt of the request for an internal appeal. The internal appeal determination letter will include:

- a statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
- the state of licensure, medical license number and the title of the person making the decision;
- a description of alternative benefits, services or supplies covered by the health benefit plan, if any; and,
- instructions for initiating an external review of the adverse determination with the Utah Insurance Department if we uphold the coverage denial on internal appeal.

External Appeal Process

Once the internal appeal/grievance process has been exhausted, You, your authorized representative or a health care provider acting on your behalf and with your consent, have the right to request an external appeal review within one hundred eighty (180) days after receipt of our adverse decision or coverage denial with the Commissioner of the Utah Insurance Department. The request for an external review must be in writing and should include all necessary information and documents pertaining to the adverse decision. As part of the request for an external review, you must provide written consent authorizing the Commissioner to obtain all necessary medical records from both us and any health care provider used for review purposes regarding the decision to deny, limit, reduce or terminate coverage. All medical records used in the external review process will be held in confidence.

You may contact the Utah Insurance Department of Insurance at:

Utah Insurance Department
3110 State Office Building
Salt Lake City, Utah 84114

Salt Lake City area: 801-538-3805
In-state toll-free: 1-800-439-3805
Fax: 1-801-538-3829

http:// www.insurance.utah.gov