BENEFIT APPEALS

RIGHT TO INTERNAL APPEAL

An insured is entitled to a full and fair review of any claim. He/she can appeal an adverse benefit determination under these claim procedures:

HOW TO FILE AN APPEAL FOR AN URGENT CARE CLAIM

Because urgent care claims have a shortened period of time to be decided, an urgent care appeal may be submitted to us by telephone at 800-371-9622, by fax to 309-346-8265, or by email to healthclaimappeal@pekininsurance.com.

The appeal should include at least the following information:

- The identity of the claimant;
- A specific medical condition or symptom;
- A specific treatment, service or product for which approval or payment is requested; and
- Any reasons why the appeal should be processed on a more expedited basis.

HOW TO APPEAL ALL CLAIMS OTHER THAN AN URGENT CARE CLAIM

An appeal of an adverse benefit decision on a claim other than an urgent care claim is filed when a claimant submits a written Request for Review form to:

Pekin Life Insurance Company
Health Claim Appeals
2505 Court Street
Pekin, IL 61558

Request for Review forms may be obtained by contacting the Pekin Life Insurance Claim Department. They are also available on our public website at www.pekininsurance.com.

A Request for Review form will be treated as received by us on the date we receive it at 2505 Court Street, Pekin, IL 61558.

A claimant has the right to submit documents, written comments, or other information in support of an appeal.

IMPORTANT APPEAL DEADLINE

The appeal of any adverse benefit decision must be filed within 180 days following the claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by us to reduce or terminate a concurrent care claim must be filed within 30 days after the claimant receives notification of our adverse benefit determination. Failure to comply with these important deadlines may cause

the claimant to forfeit any right to any further review of an adverse benefit determination under these procedures or in a court of law.

HOW YOUR APPEAL WILL BE DECIDED

When an appeal is submitted, we will provide a full and fair review. The appeal will be referred to a different individual than the person who made the initial claim decision. The person will not be a subordinate of the person who made the initial claim decision. We will follow these procedures when deciding any appeal:

a. We will take into account all the information submitted by the claimant, whether or not it was presented or available at the time of the initial claim decision. We will not give deference to the initial claim decision.
b. If the initial claim was denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on the appeal will not be the same individual who was consulted, if any, regarding the initial claim decision, or a subordinate of the first individual.
c. If a claimant requests access to copies of all documents, records, and other information relevant to their claim for benefits, we will provide the information to the claimant free of charge. If the advice of a medical or vocational expert was obtained in connection with the initial claim decision, the names of each expert consulted will be provided if requested, regardless of whether the advice was relied on by us.
d. All necessary information in connection with an urgent care appeal will be transmitted between the claimant and us by telephone, fax, or email.

TIMEFRAMES FOR DECIDING INTERNAL BENEFITS APPEALS

PRE-SERVICE CLAIMS

We will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after we receive the completed Request for Review form.

URGENT CARE CLAIMS

We will decide the appeal of an urgent care claim as soon as possible, but no later than 72 hours after we receive the Request for Review.

POST-SERVICE CLAIMS

We will decide the appeal of a post-service claim within a reasonable time but no later than 60 days after we receive the completed Request for Review form.

CONCURRENT CARE CLAIMS

We will decide the appeal of our decision to reduce or terminate an initially approved course of treatment for a concurrent care claim before the proposed reduction or termination takes place. For an appeal of a denial to extend any concurrent care claim, we will determine if the appeal is a pre-service, post-service, or urgent care appeal, and will handle the appeal accordingly.

NOTIFICATION OF THE APPEAL DECISION

We will provide written notification of the appeal decision to the claimant. If the appeal is an adverse benefit determination, we will provide the following information:

- The specific reason for the appeal decision
- A reference to the specific plan provision on which the decision is based;
- Either a statement disclosing any internal rule, guidelines, protocol or similar criteria relied on in making the adverse benefit determination, or an offer to provide such information free of charge upon request;
- Information regarding the right to an external review.

RIGHT TO AN EXTERNAL REVIEW

If our internal grievance procedure has been exhausted, and the outcome of our final internal appeal is an adverse benefit determination, a request for an external review by an Independent Review Organization may be made. The request for an external review or an expedited external review must be made with 4 months after the date of receipt of notice of an adverse determination or a final adverse determination. We will pay the cost for conducting the external review.

An external review may also be requested if we have not provided a written decision on the appeal within 30 days after it was filed, and the claimant or authorized representative has not agreed to a longer period of time for us to make a decision. An external review may also be requested if we send notification that we have waived the requirement that the internal appeals procedure must be exhausted.

REQUESTING AN EXTERNAL REVIEW

All requests for external review must be made in writing to us at:

Pekin Life Insurance Company
Health Claim Appeals
2505 Court Street
Pekin, IL 61558

Or

Consumer Advocate Bureau
Iowa Insurance Division
State of Iowa

330 Maple Street
Des Moines, IA 50319-0065
1-877-955-1212

REQUESTING AN EXPEDITED EXTERNAL REVIEW

At the same time an internal review is requested, an expedited external review may be requested, if:

- the adverse benefit determination is for an urgent care claim; or
- the final adverse determination concerns an admission, availability of care, continued stay or health care service for which emergency services were received, and the patient has not been discharged from a facility; or
- the denial of coverage is based upon a determination that the recommended or requested health care service or treatment is experimental or investigational and the treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

BINDING NATURE OF EXTERNAL REVIEW DECISION

The Independent Review Organization will provide written notice of its final external review decision to uphold or reverse the final internal adverse determination to the claimant or authorized representative, us, and the Consumer Advocate Bureau.

A final external review decision is binding upon us, except to the extent other remedies are available under applicable State law. If the Independent Review Organization reverses our final internal adverse determination, we will immediately approve the coverage that was the subject of the Independent Review.

A final external review decision is binding upon the claimant, except to the extent other remedies are available under applicable federal or State law.

A claimant may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which an external review decision has already been received.

DEFINITIONS

ADVERSE BENEFIT DETERMINATION

Means 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 an insured's eligibility to be insured under a policy. The definition also includes determinations regarding claims based on utilization review, the experimental and investigational exclusion, appropriateness,

health care setting, level of care, effectiveness of a covered benefit, and medical necessity. It also includes any rescission of coverage.

APPEAL

Means a review of an adverse benefit determination by us, as required under our internal claims and appeals procedures.

AUTHORIZED REPRESENTATIVE

Mean a person authorized to act on your behalf with respect to a benefit claim or an appeal. No person (including a treating health care professional) will be recognized as an authorized representative until we receive an Appointment of Authorized Representative form signed by the claimant. We will, however, recognize a health care professional with knowledge of the claimant's medical condition (in other words, the treating physician) as an authorized representative for urgent care claims only, except where the claimant provides specific written direction to do otherwise.

An Appointment of Authorized Representative form may be obtained from us. The completed form must be submitted to us at:

Pekin Life Insurance Company
2505 Court Street
Pekin, IL 61558
FAX # 309-346-8265
Email Address: healthclaimappeal@pekininsurance.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

Once an authorized representative is appointed, we will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless you provide specific written direction otherwise.

CLAIM

Means any request for a policy benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means an insured person who makes a request for a policy benefit or benefits in accordance with the internal claim and appeals procedures. Any reference to claimant in the section titled CLAIM AND APPEAL PROCEDURES also refers to an authorized representative of the insured person.

CONCURRENT CARE CLAIM

Means a claim where we approve an ongoing course of treatment that will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. Where an extension is requested beyond the initially approved period of time or number of treatments.

DEEMED EXHAUSTED

Means a claimant can initiate an external review because we failed to strictly adhere to the internal appeal procedure.

EXTERNAL REVIEW

Means a review of an adverse benefit determination, including a final internal adverse benefit determination, under applicable state or federal external review procedures.

FINAL EXTERNAL REVIEW DECISION

Means a determination by an independent review organization at the conclusion of an external review.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

Means:

- An adverse benefit determination that has been upheld by us at completion of the Internal Appeal Procedures; or
- An adverse benefit dermination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule in the Appeals procedure.

We provide for one level of appeal of individual health claims, and two levels of appeal for group health claims. Completion of the first level appeal with an adverse benefit determination for an individual health claim will result in a final internal adverse benefit determination, and will trigger the right to an external review. Completion of the second level appeal with an adverse benefit determination for a group health claim will result in a final internal adverse benefit determination, and will trigger the right to an external review.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

POST-SERVICE CLAIM

Means any claim for benefit under this policy that is not a pre-service claim or an urgent care claim.

PRE-SERVICE CLAIM

Means a claim for benefits under the policy for services that are not covered under the policy unless approval in advance is obtained.

RESCISSION OF COVERAGE

Means any cancellation or discontinuance of coverage that has a retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

URGENT CARE CLAIM

Any pre-service claim for medical care or treatment where, in the opinion of a physician with knowledge of the claimant's medical condition, a delay in determining if the service is approved under the policy could seriously jeopardize the claimant's life or health, or ability to regain maximum function.

Upon receipt of a pre-service claim, we will make a determination if it is an urgent care claim. However, if a physician with knowledge of the claimant's medical condition determines that the claim is an urgent care claim, we will treat the claim as an urgent care claim.

YOU

Means a covered person under this policy.