# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")


**POLICY NUMBER:** VC-146

**POLICYHOLDER:** Marsh & McLennan Agency – UMW Region

**POLICY EFFECTIVE DATE:** January 1, 2020

**POLICY ANNIVERSARY DATE:** January 1 of the following year and each January 1 thereafter

Fidelity Security Life Insurance Company represents that the Insured Person is insured for the benefits described in the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number, and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson T. Jones — Bradford R. James

President — Secretary

**GROUP VISION INSURANCE CERTIFICATE**
**THIS IS A LIMITED BENEFIT CERTIFICATE**
***Please read the Certificate carefully.***

**THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.**

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## DEFINITIONS

**Allowance** means the benefit amount shown in the Schedule of Benefits that is the maximum amount payable by the Company, subject to the expenses incurred. The Insured Person is responsible for any amounts due above the Allowance. The Allowance cannot be used to satisfy a Copayment.

**Benefit Frequency** means the period of time in which a benefit is payable as shown in the Schedule of Benefits.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

**Copayment** or **Copay** means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

**Comprehensive Eye Examination** means a general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.

**Dependent** means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child of the Insured or the Insured's spouse who is under 26 years of age;
3. each unmarried child at least 26 years of age who is primarily dependent upon the Insured or the Insured's spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap.

Coverage for an unmarried Dependent child who is a full-time student will continue if such Dependent child is required to take a leave of absence from school due to illness or injury. For coverage to continue, the Company may require the Dependent child's attending physician to certify to the Company, in writing, that it is medically necessary for the Dependent child to take a leave of absence from school. This continued coverage will terminate on the earlier of: 1) 12 months from the last day of attendance in school; or 2) the limiting age for a Dependent child who is a full-time student.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

**Domestic Partner** means a same-sex or an opposite-sex adult who is in a committed relationship with the Insured and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. The term "spouse," wherever used, will include a Domestic Partner.

**Formulary** means a list, provided by the Company, of Vision Materials by tier, that are covered under the Policy as shown in the Schedule of Benefits.

**Insured** means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

**Insured Person** means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

**In-Network Provider** means a Provider who has signed a Preferred Provider Agreement with the PPO.

**Medically Necessary Contact Lenses** means that adequate functional vision correction cannot be achieved with spectacles but can be achieved with contact lenses. Conditions that qualify for Medically Necessary Contact Lenses are:

1. Anisometropia of 3D in meridian powers;
2. High Ametropia exceeding -12D or +12D in meridian powers;
3. Keratoconus when vision is not correctable to 20/25 in either eye or both eyes using standard spectacle lenses; or
4. vision impairments, other than Keratoconus, when vision can be improved by two lines on the visual acuity chart when compared to best corrected standard spectacle lenses.

**Out-of-Network Provider** means a Provider, located within the PPO Service Area, but is not an In-Network Provider.

**Policy** means the Vision Insurance Policy issued to the Policyholder.

**Policyholder** means the employer named as the Policyholder in the face page of the Policy.

**PPO Service Area** means the geographical area where the PPO is located.

**Preferred Provider Agreement** means the agreement between the PPO and a Provider who agrees to become an In-Network Provider. The Preferred Provider Agreement contains the rates and reimbursement methods for services and supplies furnished by an In-Network Provider.

**Preferred Provider Organization ("PPO")** means a network of Providers and retail chain stores within the PPO Service Area that have signed a Preferred Provider Agreement.

**Provider** means a licensed physician or optometrist who is operating within the scope of his or her license. Provider also includes a dispensing optician.

**Refraction** means a test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

**Vision Examination** means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

**Vision Materials** means those materials provided for visual health and welfare shown in the Schedule of Benefits.

## EFFECTIVE DATES

**Effective Date of Insured's Insurance.** The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured becomes eligible, provided;
   a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured becomes eligible; and
   b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

**Effective Date of Dependents' Insurance.** Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

**Newborn Children.** A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

**Adopted Children.** If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or a greater number of days, if elected by the Policyholder. To continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

## BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

**In-Network Provider Benefits.** The Insured Person must pay any Copayment or any cost above the Allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company on behalf of the Insured Person.

**Out-of-Network Provider Benefits.** The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company, unless the Out-of-Network Provider allows assignment of benefits. The Company will pay the Out-of-Network benefits up to the maximum dollar amount shown in the Schedule of Benefits.

## LIMITATIONS

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same Benefit Frequency.

## EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;

5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses;
10. plano (non-prescription) contact lenses;
11. two pair of glasses in lieu of bifocals;
12. electronic vision devices;
13. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
14. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

## TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

**For All Insureds.** The Insureds' insurance will cease on the earlier of:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
   a. does so without individual selection between Insureds; and
   b. continues to pay any premium contribution for those individuals.

**For Dependents.** A Dependent's insurance will cease on the earlier of:

1. the date the Insured's coverage ends;
2. the date the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not request it more than once a year after this coverage has been continued for two years. This continued coverage will end on the earlier of:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

## PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company by the Policyholder on behalf of the Insured Person. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date. The initial premium rates are shown in the Policyholder's application.

**Premium Changes.** The Company has the right to change the premium rates on any premium due date as allowed in the Policy. The Company will provide written notice to the Policyholder at least 31 days before the date of the change. The premium rates also may be changed at any time the terms of the Policy are changed.

**Grace Period.** The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. Coverage will terminate at the end of the grace period if all premiums due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period. The grace period will not apply if the Company receives written notice of the Policyholder's or the Insured's intent to terminate coverage.

**Unpaid Premium.** When a claim is paid during the grace period, any premium due and unpaid for the Insured Person will be deducted from the claim payment.

## CLAIMS

**Notice of Claim.** Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

**Claim Forms.** The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

**Proof of Loss.** Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

**Time Payment of Claims.** Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

**Payment of Claims**. All claims will be paid to the Insured, unless assigned. Any benefits payable on or after the Insured's death will be paid to the Insured's estate.

**Assignment.** Benefits under the Policy may be assigned.

**Right of Recovery.** If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

**Legal Actions.** No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of six years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

## GENERAL PROVISIONS

**Clerical Error.** Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

**Conformity to Law.** Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

**Entire Contract.** The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement will be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

**Amendments and Changes.** No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

**Incontestability.** After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

**Insurance Data.** The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

**Workers' Compensation.** The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

# SCHEDULE OF BENEFITS

**March & McLennan Agency – UMW Region – Option Low**

| *BENEFIT FREQUENCY* | | |
|---|---|---|
| **Vision Examination** | once every 12 months | Insured Person |
| **Vision Materials** | | |
| **Frame** | once every 24 months | Insured Person |
| **Lenses** | once every 12 months | Insured Person |
| **Contact Lenses** | once every 12 months | Insured Person |

| *BENEFIT* | *In-Network Provider* | *Out-of-Network Provider* *(Reimbursement up to)* |
|---|---|---|
| **Vision Examination** | | |
| **Comprehensive Eye Examination** | $10 Copayment | $50 |
| **Vision Materials** | | |
| **Frame** | $0 Copayment up to $130 Allowance | $65 |
| **Contact Lenses** Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses. | | |
| Conventional | $0 Copayment up to $130 Allowance | $104 |
| Disposable | $0 Copayment up to $130 Allowance | $104 |
| Medically Necessary | Paid in Full | $300 |
| **Standard Plastic Lenses** | | |
| Single Vision | $25 Copayment | $50 |
| Bifocal | $25 Copayment | $75 |
| Trifocal | $25 Copayment | $100 |
| Lenticular | $25 Copayment | $100 |
| Progressive – Standard | $90 Copayment | $75 |
| Progressive – Premium Tier 1 | $110 Copayment | $75 |
| Progressive – Premium Tier 2 | $120 Copayment | $75 |
| Progressive – Premium Tier 3 | $135 Copayment | $75 |
| Progressive – Premium Tier 4 | $90 Copayment up to $120 Allowance | $75 |

# SCHEDULE OF BENEFITS

**Marsh & McLennan Agency – UMW Region – Option High**

| *BENEFIT FREQUENCY* | | |
|---|---|---|
| **Vision Examination** | once every 12 months | Insured Person |
| **Vision Materials** | | |
| **Frame** | once every 12 months | Insured Person |
| **Lenses and Lens Options** | once every 12 months | Insured Person |
| **Contact Lenses** | once every 12 months | Insured Person |

| *BENEFIT* | *In-Network Provider* | *Out-of-Network Provider* *(Reimbursement up to)* |
|---|---|---|
| **Vision Examination** | | |
| **Comprehensive Eye Examination** | $10 Copayment | $50 |
| **Vision Materials** | | |
| **Frame** | $0 Copayment up to $175 Allowance | $88 |
| **Contact Lenses** Only one of the following Contact Lenses benefits may be used for the Contact Lenses benefit. Contact Lenses are in lieu of Lenses and Lens Options. | | |
| Conventional | $0 Copayment up to $175 Allowance | $140 |
| Disposable | $0 Copayment up to $175 Allowance | $140 |
| Medically Necessary | Paid in Full | $300 |
| **Standard Plastic Lenses** | | |
| Single Vision | $10 Copayment | $50 |
| Bifocal | $10 Copayment | $75 |
| Trifocal | $10 Copayment | $100 |
| Lenticular | $10 Copayment | $100 was $125 |
| Progressive – Standard | $75 Copayment | $75 |
| Progressive – Premium Tier 1 | $95 Copayment | $75 |
| Progressive – Premium Tier 2 | $105 Copayment | $75 |
| Progressive – Premium Tier 3 | $120 Copayment | $75 |
| Progressive – Premium Tier 4 | $75 Copayment up to $120 Allowance | $75 |
| **Lens Options** | | |
| Anti-Reflective Coating – Standard | $0 Copayment | $32 |
| Anti-Reflective Coating – Premium Tier 1 | $12 Copayment | $32 |
| Anti-Reflective Coating – Premium Tier 2 | $23 Copayment | $32 |
| Anti-Reflective Coating – Premium Tier 3 | $100 Copayment | $32 |
| Polycarbonate Lenses – Standard | $0 Copayment | $28 |

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## AMENDATORY RIDER REGARDING REPLACEMENT COVERAGE

The Policy/Certificate to which this Amendment Rider is attached is amended as follows:

The following applies when the Policy serves to replace similar coverage the Policyholder previously obtained through another plan or policy. In this provision, that other plan or policy is referred to as the prior plan. The Policyholder's coverage under the Policy will not be considered as replacement coverage unless the Policyholder's coverage under the Policy takes effect within 60 days after coverage under the prior plan ends.

In the absence of this provision, an Insured Person who was covered by the prior plan at the date of discontinuance might not qualify for coverage under the Policy because the person is not actively at work or is confined in a Hospital.

Each such person will be insured under the Policy if:

1. the person was insured under the prior plan, including coverage under the prior plan's extension of benefits provision, on the date the Policyholder's coverage with the prior plan ended;
2. the prior plan covered more than 15 people; and
3. the person is in a class of persons eligible for coverage under the Policy.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the prior plan pursuant to any extension of benefits provision.

The Policy, in applying any waiting periods, will give credit for the satisfaction or partial satisfaction of the same or similar provisions under the prior policy.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the terms and conditions of the Policy/Certificate except as stated herein.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Bryson Z. Jones — President

Bradford R. James — Secretary

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## Health Care Insurer Appeals/Grievance Process Information Packet

Please read this notice carefully. This notice contains important information about how to appeal adverse decisions made by your insurer.

### I. Levels of Review

You may ask your insurer to review its decision involving your request for service or your request to have your claim paid. In general, the following three levels will be available to you:

Level 1 Expedited Medical Review
Level 2 Formal Grievance Appeal
Level 3 External Review

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 Formal Grievance Appeal process could cause a significant negative change in your medical condition.

Covered service not yet provided. Your insurer has 15 calendar 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, if the grievance involves review of an adverse determination.

**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 Grievance Appeal (Level 2).

Covered service already 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, if the grievance involves review of an adverse determination

**2. Decision:**

After receiving the certification and the supporting documentation, the insurer has 72 hours total 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 External Review (Level 3) within 10 days of the adverse determination.

**b. Denial reversed**

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

**B. Formal Grievance Appeal (Level 2)**

**1. Eligibility**

a. If you have a grievance (see definition under X), you may send a written request for Formal Grievance Appeal to:

First American Administrators, Inc.
ATTN: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
Or you may call our toll-free number at:
1-877-226-1115

b. If your grievance involves the denial by your insurer of a covered service not yet provided, you may send written request for Formal Grievance Appeal within 60 days of notice of denial.

c. If your grievance involves the denial by your insurer of a covered service already provided but not yet paid for, you may send written request for Formal Grievance Appeal within two years of notice of denial.

If you pursue a grievance under b. or c., you or your physician or treating provider must give the insurer any material justification or documentation to support your request for the service.

**2. Review Committee**

You also have the right to request an appearance before a designated committee of the insurer to present your grievance when you file your grievance request under 1. above.

**3. Deadlines Applicable to the Formal Process**

Covered service not yet provided. Your insurer has 30 calendar 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, if the grievance involves review of an adverse determination.

Covered service already provided. Your insurer has 60 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, if the grievance involves review of an adverse determination

The time period may be tolled for up to ten days (total of 40 days) for the insurer to request and receive information from a health care facility or health professional and for any period of time you may need to request and receive additional information.

**4. 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.

If you disagree with the insurer's decision concerning your grievance, you have a right to pursue an External Review (Level 3).

**5. Expedited Grievance**

If you have an expedited grievance (see definition under X), your insurer must make a decision not later than 72 hours after receipt of such grievance.

If the insurer's decision is made orally to you or your health care provider, the insurer will provide a written confirmation of the decision to you not later than two business days after the oral decision.

Within ten days after receipt of the insurer's decision, the insured or the insured's authorized representative may request a determination of the matter under External Review (Level 3).

## C. External Review (Level 3)

**1. Eligibility**

You may obtain External Review only after you have sought any available Expedited Medical Review (Level 1) or Formal Grievance Appeal (Level 2), which are discussed above. You will receive a copy of an external review form entitled "Health Care Request for External Review."

**2. External Review Process**

a. **Preliminary determination by superintendent**

Not later than 127 days after the date of receipt of a notice of an adverse determination or final adverse determination, you or your authorized representative may file a request for an External Review with the Director of the Michigan Department of Insurance and Financial Services. Upon receipt of such request, the Director will immediately notify and send a copy of the request to your insurer.

**Reviews that do not involve experimental or investigational service or treatment**

Not later than five business days after the date of receipt of a request for an External Review, the Director will complete a preliminary review of the request to determine all of the following:

- Whether you are or were in the plan at the time the health care service was requested or, in the case of a retrospective review, were covered by the health benefit plan at the time the health care service was provided.
- Whether the health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under your plan.
- Whether you have exhausted the insurer's internal grievance process unless you require an Expedited External Review (See C.4.).
- You have provided all the information and forms required by the Director that are necessary to process an External Review, including the health information release form.

**Reviews that involve issues of experimental or investigational service or treatment**

Not later than five business days after the date of receipt of a request for an External Review, the Director will complete a preliminary review of the request to determine all of the following:

- Whether you are or were in the plan at the time the health care service was requested or, in the case of a retrospective review, were covered by the health benefit plan at the time the health care service was provided.
- Whether the recommended or requested service or treatment that is the subject of the adverse determination or final adverse determination is both of the following:
  - A covered benefit under your plan except for the insurer's determination that the service or treatment is experimental or investigation for a particular medical condition.
  - Whether the experimental or investigational service or treatment is excluded under your plan.
- Whether your treating physician has certified that one or more of the following situations are applicable:
  - Standard health care services or treatments have not been effective in improving your condition.
  - Standard health care services or treatments are not medically appropriate for you.
  - There is no available standard health care service or treatment covered by the insurer that is more beneficial than the recommended or requested health care service or treatment.
- Whether your treating physician has done either of the following:
  - Certified in writing that the recommended health care service or treatment, is likely to be more beneficial to you, in his/her opinion, than any available standard health care services or treatments.
  - If your physician is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, certifies in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by you that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to you than any available standard health care services or treatments.
- Whether you have exhausted the insurer's internal grievance process unless you require an Expedited External Review (See C.4.).
- You have provided all the information and forms required by the Director that are necessary to process an External Review, including the health information release form.

In addition to the documents and information that are required above, the reviewing entity, in reaching a recommendation, shall consider whether either of the following applies**:**

- The recommended or requested health care service or treatment has been approved by the United States Food and Drug administration, if applicable, for the condition.
- Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to you than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

Upon completion of the preliminary review, the Director will immediately provide a written notice to you and, if applicable, your authorized representative as to whether the request is complete and whether it has been accepted for External Review.

If the request is accepted for External Review, the Director will do both of the following:

- Include in the written notice a statement that you or your authorized representative may submit to the Director in writing within seven days following the date of receipt of the notice additional information and supporting documentation that the independent review organization will consider when conducting the External Review.
- Immediately notify the insurer in writing of the acceptance of the request for External Review.

If a request is not accepted for External Review because the request is not complete, the Director will inform you and, if applicable, your authorized representative what information or materials are needed to make the request complete. If a request is not accepted for External Review, the Director will provide written notice of the reasons for its nonacceptance.

b. **Review procedures**

At the time a request is accepted for External Review, the Director will assign an approved independent review organization to conduct the External Review and to provide a written recommendation on whether to uphold or reverse the adverse determination or the final adverse determination.

The independent review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process.

Not later than seven business days after the insurer receives notice from the Director of acceptance of the request for External Review, the insurer or its utilization review organization will provide to the independent review organization the documents and any information considered in making the adverse determination or the final adverse determination. Failure by the insurer or its utilization review organization to provide the documents and information within seven business days will not delay the conduct of the External Review.

If the insurer fails to provide the documents and information within seven business days, the Director may terminate the External Review and make a decision to reverse the adverse determination or final adverse determination. The Director will immediately notify the independent review organization, you, if applicable, your authorized representative, and the insurer of his or her decision.

The independent review organization will review all of the information and documents received and any other information submitted in writing by you or your authorized representative that has been forwarded to the independent review organization by the Director. At the same time the Director forwards the information to the independent review organization, the Director will also forward the information to the insurer.

The insurer may reconsider its adverse determination or final adverse determination that is the subject of the External Review. Reconsideration by the insurer will not delay nor terminate the External Review. External Review may only be terminated if the insurer decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. Immediately upon making the decision to reverse its determination, the insurer will notify you or your authorized representative, the independent review organization, and the Director in writing of its decision. The independent review organization will terminate the External Review upon receipt of such other notice.

In addition to the documents and information provided to the independent review organization, such organization may also consider the following in reaching a recommendation:

- Your pertinent medical records.
- The attending health care professional's recommendation.
- Consulting reports from appropriate health care professionals and other documents submitted by the insurer, you, or your authorized representative, or your treating provider.
- The terms of coverage under your health benefit plan.
- The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by the insurer or its utilization review organization.

The independent review organization will provide its recommendation to the Director not later than 14 days after acceptance by the Director of the request for an External Review. The independent review organization shall include in its recommendation all of the following:

- A general description of the reason for the request for External Review.
- The date the independent review organization received the assignment from the Director to conduct the External Review.
- The date the External Review was conducted.
- The date of its recommendation.
- The principal reason or reasons for its recommendation.
- The rationale for its recommendation.
- References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

**3. Decision**

Upon receipt of the independent review organization's recommendation, the Director will immediately review the recommendation to ensure that it is not contrary to the terms of coverage under the insured's health benefit plan with the insurer.

The Director will provide written notice to you, or your authorized representative, and the insurer of the decision to uphold or reverse the adverse determination or the final adverse determination not later than seven business days after the date of receipt of the recommendation. The Director will include in this notice all of the following:

- The principal reason or reasons for the decision, including the information provided by the independent review organization.
- If appropriate, the principal reason or reasons why the Director did not follow the assigned independent review organization's recommendation.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the insurer will immediately approve the coverage that was the subject of the External Review.

You or your authorized representative may not file a subsequent request for External Review involving the same adverse determination or final adverse determination for which you have already received an External Review decision.

**4. Expedited External Review**

You or your authorized representative may make a request for an Expedited External Review with the Director within ten days after you receive an adverse determination if both of the following are met:

- The adverse determination involves a medical condition of yours for which the time frame for completion of an Expedited Grievance (see B.5.) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function as substantiated by a physician either orally or in writing.
- You or your authorized representative has filed a request for an Expedited Grievance (see B.5.).

At the time the Director receives a request for an Expedited External Review, the Director will immediately notify and provide a copy of the request to the insurer that made the adverse determination or final adverse determination. If the Director determines the request meets the reviewability requirements under 2.a., the Director will assign an independent review organization to conduct the Expedited External Review and to provide a written recommendation to the Director on whether to uphold or reverse the adverse determination or final adverse determination.

If you have not completed the Expedited Grievance process, the independent review organization will determine immediately after receipt of the assignment to conduct the Expedited External Review whether you will be required to complete the Expedited Grievance (see B.5.) prior to conducting the Expedited External Review. If the independent review organization determines that you must first complete the Expedited Grievance (see B.5.) process, the independent review organization will immediately notify you and your authorized representative of this determination and that it will not proceed with the Expedited External Review until the covered person completes the Expedited Grievance (see B.5.).

In reaching a recommendation, the independent review organization is not bound by any decisions or conclusions reached during the insurer's utilization review process or internal grievance process.

Not later than twelve hours after the insurer receives the notice, it or its utilization review organization will provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the independent review organization electronically or by telephone or facsimile or any other available expeditious method.

In addition to the documents and information provided or transmitted above, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, will consider the following in reaching a recommendation:

- Your pertinent medical records.
- The attending health care provider's recommendation.
- Consulting reports from appropriate health care providers and other documents submitted by the insurer, you, your authorized representative, or your treating provider.
- The terms of coverage under your health benefit plan.
- The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by the insurer or its utilization review organization in making adverse determinations.

The independent review organization will provide its recommendation to the Director as expeditiously as the insured's medical condition or circumstances require, but in no event more than 36 hours after the date the Director received the request for an Expedited External Review.

Upon receipt of the independent review organization's recommendation, the Director will immediately review the recommendation to ensure that it is not contrary to the terms of coverage under the health benefit plan.

As expeditiously as your medical condition or circumstances require, but in no event more than 24 hours after receiving the recommendation of the independent review organization, the Director will complete the review of the independent review organization's recommendation and notify you or your authorized representative, and the insurer of the decision to uphold or reverse the adverse determination or final adverse determination. If this notice was not in writing, within 2 days after the date of providing that notice, the Director will provide written confirmation of the decision to you, your authorized representative, and the insurer and include the information required in C.3.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the insurer will immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

An Expedited External Review will not be provided for retrospective adverse determinations or retrospective final adverse determinations.

## 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.

## VI. Additional Remedies

The External Review (Level 3) does not preclude an insurer from seeking other remedies under applicable state law nor does it preclude you from seeking other remedies under federal or state law.

## VII. Complaints and Responses

Copies of all complaints and responses will be available at our principal office for inspection by the Michigan Insurance Bureau for two (2) years following the year the complaint was filed.

## VIII. Review

Period management and governing body review will be made of all data to ensure that appropriate actions have been taken.

## IX. Summary Data

Summary data on the number and types of complaints and grievances will be filed annually with the Director of the Michigan Department of Insurance and Financial Services.

## X. Definitions

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, has been based on the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

"Expedited grievance" means one in which the insured's health care provider submits, orally or in writing, evidence that the time frame for a grievance under B.3. would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function.

"Final Adverse Determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures.

"Grievance" means a complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.
(ii) Benefits or claims payment, handling, or reimbursement for health care services.
(iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer or health maintenance organization.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")


**Health Care Insurer Grievance/Appeals Process Information Packet**
**For Residents of the State of Michigan**

Name, address and phone numbers for person responsible for Insurer's internal grievance/appeal process:

First American Administrators, Inc.
ATTN: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040
Or you may call our toll-free number at:
1-877-226-1115

IMPORTANT NOTICE!

You or your designated health care provider may request:

- Review by your Insurer of any adverse determination as outlined in the attached Appeals Process Information Packet.
- An appearance before a designated committee of the Insurer to present a grievance during a formal grievance appeal under Level 3 as outlined in the attached Appeals Process Information Packet.
- Review by the Director of the Michigan Department of Insurance and Financial Services, or his designee, of any final determination made by the Insurer. The Director may be contacted by:

Office of General Counsel - Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

Delivery Service
Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Email
DIFS-HealthAppeal@michigan.gov.

Online portal
*https://difs.state.mi.us/Complaints/ExternalReview.aspx*

Toll Free Number
1-877-999-6442

Fax
517-284-8838

MICHIGAN GRIEVANCE PROCEDURES:

Some decisions by your Insurer may result in a grievance. A "grievance" is a complaint you have with the Insurer that could pertain to:

- the availability, delivery, or quality of health care services and includes complaints regarding an "adverse determination" made pursuant to utilization review; or
- benefits or claims payments, handling or reimbursement for health care services; or
- matters pertaining to the contractual relationship between you and your Insurer.

An "adverse determination" means a determination by the Insurer or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the Insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination

For any grievance you may have with your Insurer regarding an adverse determination or relating to benefits/claim payments or the handling or reimbursement for health care services, please refer to the attached Health Care Insurer Appeals Process Information Packet which explains in detail your right to appeal decisions of your Insurer. For any other grievance or complaint, direct your concerns in writing to Legal Department, Fidelity Security Life Insurance Company, 3130 Broadway, Kansas City, MO 64111.

# FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")


## NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for First American Administrators, Inc. to provide administrative services for your insurance plan. As administrator, First American Administrators, Inc., is authorized to process claim payments, and perform other services, according to the terms of its agreement with the insurance company. First American Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

As First American Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against First American Administrators, Inc. than would otherwise be afforded to you by law.