APPEALS PROCEDURES
Commonwealth of Kentucky

Utilization Review – We may perform a retrospective review of your claim to determine that the services, supplies, and treatments or services received by the Covered Person were medically necessary, appropriate, effective, and/or efficient. We do not perform pretreatment certification or prospective or concurrent reviews.

Review of Claim – If we send you a written statement denying your claim in whole or in part, you may submit a written appeal to us. A written decision with respect to the appeal will be sent to you within **30 days** after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to you as soon as possible.

Internal Appeals Process

Appeal of Denied Claim – If we denied a claim, you may appeal the denial. Both you and our company must take the following steps to complete an appeal (in other words a decision review).

Here are the procedures you or your attending physician must follow:

a. Write to us at the following address: Transamerica Life Insurance Company, Administrative Offices, 6400 C Street SW, Cedar Rapids, IA 52499, Attention: Grievance Coordinator, 800-PYRAMID (797-2643), within **60 days** of the date on the notice of your claim denial
b. State why the claim should not have been denied
c. Include the denial notice and any other documents, data information, or comments that you believe may have an influence on the appeal of the claim
d. If requested, you will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim

External Review Process

External Review of Denied Claim – Once you have exhausted the Internal Appeal Process, you may request an External Review following an Adverse Determination and the completion of the Internal Appeals process or if a written decision with respect to the Internal Appeal Process was not sent to you within **30 days** after its completion.

Here are the procedures you or your attending physician must follow:

a. Write to us at the following address: Transamerica Life Insurance Company, Administrative Offices, 6400 C Street SW, Cedar Rapids, IA 52499, Attention: Grievance Coordinator, 800-PYRAMID (797-2643), within **120 days** of the date on the notice of your claim denial
b. Include a written consent authorizing the Independent Review Entity to obtain all necessary medical records
c. Submit a filing fee of $25.00

Definitions

"Adverse determination" means a determination by an insurer or its designee that the healthcare services furnished or proposed to be furnished to a covered person are: 1) Not medically necessary, as determined by the insurer or its designee, or experimental or investigational, as determined by the insurer or its designee; and 2) Benefit coverage is therefore denied, reduced, or terminated.

"Adverse determination**"** does not mean a determination by an insurer or its designee that the healthcare services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan.

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"Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay.

"External review" means a review that is conducted by an independent review entity that meets specified criteria as established under External Review Process, Independent External Review, and Independent Review Entity.

"Independent review entity" means an individual or organization certified by the department to perform external reviews under External Review Process, Independent External Review, and Independent Review Entity.

"Internal appeals process" means a formal process, established and maintained by the insurer, its designee, or agent whereby the covered person or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent.

"Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment.

"Retrospective review" means utilization review that is conducted after healthcare services have been provided to a covered person. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels or adjudication of payment.

"Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review.

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