

**Health Care Insurer Appeals Process Information Packet
ReliaStar Life Insurance Company**

**CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT
FOR FUTURE REFERENCE. IT HAS IMPROTANT INFORMATION ABOUT
HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.**

**Getting Information About the Health Care Appeals Process
Help in Filing an Appeal: Standardized Forms and Consumer Assistance Form
The Department of Insurance**

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at (877) 527-6173 to ask.

At the back of this packet you will find forms you can use for your appeal. The Arizona Insurance Department (“the Department”) developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Assistance Office at (602) 912-8444 or (800) 325-2548 or call us at (877) 527-6173.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not pay for a service that you have already received.
2. We do not pay for a claim because we say that it is not “medically necessary.”
3. We do not pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of “usual and customary charges.”
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th, Second Floor, Phoenix, AZ 85018.

Who Can File An Appeal?

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

The standard appeals process has 3 levels:

Level 1	Informal Reconsideration*
Level 2	Formal Appeal
Level 3	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal at Level 3.

*Informal reconsideration is not available for a denied claim. Therefore, since we do not require preauthorization of services and any action is taken only after submission of a claim, we do not provide for a Level 1 appeal. All appeals will begin at Level 2 - Formal Review.

STANDARD APPEAL PROCESS FOR DENIED CLAIMS
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Level 1. Informal Reconsideration

Not applicable. All appeals will begin at Level 2 - Formal Appeal.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if you have an unpaid claim. You have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name:	Barbara Chipres	Phone:	(877) 527-6173
Title:	Compliance Manager	Fax:	(805) 383-1792
Address:	5171 Verdugo Way Camarillo, CA 93012		

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 30 days to appeal to Level 3.

If we grant your request: We will pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Level 2. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Name:	Barbara Chipres	Phone:	(877) 527-6173
Title:	Compliance Manager	Fax:	(805) 383-1792
Address:	5171 Verdugo Way Camarillo, CA 93012		

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to pay a claim because we think the services that were provided were not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contact Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's determination of coverage issues, we may also request a hearing at the OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. The OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and 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.

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.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal 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 people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires “any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed” by law. This means that, for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgement, 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.

HEALTH CARE APPEAL REQUEST FORM

RELIASTAR LIFE INSURANCE COMPANY

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name _____ Member ID # _____
Name of representative pursuing appeal, if different from above _____
Mailing Address _____ Phone # _____
City _____ State _____ Zip Code _____

Type of Denial: Denied Claim

Name of Insurer that denied the claim: _____

What decision are you appealing? _____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 912-8444 or (800) 325-2548, or ReliaStar Life Insurance Company at (877) 527-6173

Make sure to attach everything that shows why you believe your insurer should cover your claim, including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)

Signature of insured or authorized representative

Date

For Arizona Residents:

**NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE
ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA.
PLEASE READ THIS CERTIFICATE CAREFULLY.**

R-06702



Applicable to Arkansas residents

Please insert this notice in your certificate.

CONSUMER NOTICE: The nearest servicing office is our Dallas Regional Office, Jeff Flanagan, Manager. The telephone number for this office is (972) 419-5760.

If we at ReliaStar Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, Arkansas 72201

Telephone: (501) 371-2640
Toll Free in AR: (800) 852-5494

This consumer notice is for information only and does not become a part or condition of this certificate.

California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association (“CLHIGA”). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers’ care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance
Guarantee Association
P.O. Box 17319
Beverly Hills, CA 90209-3319

California Department of Insurance
Consumer Communications Bureau
or 300 South Spring Street, South Tower
Los Angeles, CA 90013

Below is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

(please turn over)

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or any portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNTS OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to
 - \$100,000 in cash surrender values,
 - \$100,000 in present value of annuities, or
 - \$250,000 in life insurance death benefits.
- A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.



ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401

NOTICE TO CALIFORNIA
POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-612-372-5432.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013**

**Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921**

R-08246

CALIFORNIA CERTIFICATEHOLDERS

IF YOU ARE AGE 65 OR OLDER ON THE EFFECTIVE DATE OF YOUR SUPPLEMENTAL LIFE INSURANCE COVERAGE UNDER THE GROUP POLICY, YOU HAVE 30 DAYS FROM THE DATE YOU RECEIVE THIS CERTIFICATE, IF NO BENEFITS HAVE BEEN PAID, TO RETURN THE CERTIFICATE TO THE POLICYHOLDER AND HAVE THE FULL PREMIUM FOR SUPPLEMENTAL LIFE INSURANCE REFUNDED.

R-08250

FLORIDA RESIDENTS:

The benefits of the policy providing your coverage are governed primarily by the Law of a state other than Florida.

R-03404

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

For Florida Residents only: Upon submission of verification from the Office of the Attorney General, Division of Victims Services, deductibles, copayment and coinsurance amounts will be waived for covered services treating crime-related injuries as provided by the Florida Crimes Compensation Act.

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to Florida Residents

The **DENTAL INSURANCE** section of your group dental insurance certificate for you (and your insured dependents, if your certificate includes Dependent's Insurance) is revised as indicated below.

The provision entitled **Extended Coverage After Dental Insurance Ends** is replaced by the following:

Extended Coverage After Dental Insurance Ends

Certain procedures may be covered beyond the date your or your insured dependent's insurance ends, unless such insurance was ended voluntarily by you. These procedures are root canal treatments, dentures, crowns, bridges, and other laboratory processed restorations. A procedure begins when a service is performed on the teeth or gums. For purposes of this extension provision, a procedure does not include diagnostic services such as x-rays or initial treatment impressions.

For coverage to be extended:

- The procedure must begin before your or your insured dependent's Dental Insurance ends under the Group Policy, and
- The procedure must be completed within 90 days after your or your insured dependent's Dental Insurance ends under the Group Policy.

This extension will terminate on the earlier of:

- The end of the 90 day extension period; or
- The date you or your insured dependent become covered under another policy providing similar dental benefits. **Exception:** If the services being extended are not covered under the new policy due to a waiting period not being satisfied, the extension will not end.

All other provisions of your certificate remain unchanged.

R-08196a

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South
Minneapolis, Minnesota 55401

**NOTICE CONCERNING COVERAGE LIMITATIONS
AND EXCLUSIONS UNDER THE HAWAII LIFE AND
DISABILITY INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Hawaii who purchase life insurance, annuities, or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumer's care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The Hawaii Life and Disability Insurance Guaranty Association

P.O. Box 4068

Honolulu, Hawaii 96812

Department of Commerce and Consumer Affairs

Insurance Division

P.O. Box 3614

Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if –

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does **not** provide coverage for –

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender values, \$100,000 in disability insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

For Maryland Residents:

**NOTICE: THIS CERTIFICATE OF INSURANCE MAY
NOT PROVIDE ALL BENEFITS REQUIRED FOR A
POLICY ISSUED AND DELIVERED IN MARYLAND.**

R-07624

NOTICE: THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL OF THE BENEFITS REQUIRED BY MARYLAND LAW.

R-08159

CERTIFICATE BOOKLET RIDER

Applicable to Minnesota Residents

Under Minnesota law, if you stop active work because your employment terminates, you retire, or your hours are reduced, you may continue your Life Insurance (and if covered, your Dependents' Life Insurance) up to the earliest of the following:

- The date you become covered under any other group life policy.
- The end of the 18 month period following the date you stop active work or begin to work fewer hours than required under the definition of employee.
- The date the Group Policy terminates.

If you continue your insurance due to working fewer hours than required under the definition of employee and then you stop active work, no additional time period for continuation of insurance other than the original 18 months is available to you due to your stopping active work.

You have a duty to elect to continue your insurance. Your employer will inform you of this duty. You have 60 days in which to elect continuation coverage. This election period begins on the **later** of:

- the date coverage would terminate, or
- the date notice of the right to continue coverage is received.

If you do not make the election during that 60 days, you will have forfeited the right to continue. Details are available from your employer.

At the end of the continuation period, you or your insured dependent may purchase an individual term life conversion policy for the amount of Life Insurance which stopped.

National Dental Grievance, Complaints, Appeals Process

Application: All UNICARE business.

Definitions:

Inquiries* and Complaints* are questions or concerns from insureds regarding any aspect of UNICARE's operation which may include (but are not limited to):

- Claims payment, handling or reimbursement for dental care services
- Matters pertaining to the contractual relationship between an insured and UNICARE

Grievances* are an insured's dissatisfaction with:

- The availability, accessibility, or delivery of services by network providers
- The response to an insured's concern

Appeals* are requests by insureds for reconsideration of a claim determination or pre-authorization made by UNICARE in accordance with the client's plan with respect to benefits payable under the plan. Appeals are written requests for a second review.

Adverse Determination is a determination that a health care service has been reviewed and was denied on the basis that the service was not medically necessary.

Insured is an individual or entity (or the authorized representative of an individual or entity) to whom UNICARE provides services. Specifically, this definition of insured includes, but is not limited to, clients, patients, enrollees, dental care providers or provider facilities (or their authorized representative).

Purpose: To provide a fair and reasonable process for handling inquiries, complaints grievances and appeals from insureds.

Overview: The following guidelines are to set forth the UNICARE policy and procedures for resolution of complaints, grievances and appeals; and are subject to all state and federal laws and specific plan provisions.

UNICARE Dental Services may receive inquiries, complaints, grievances and appeals either by telephone through the Customer Service Unit (CSU) or by mail to the Technical Support Unit (TSU). Dental Services Associates will record all inquiries, complaints, grievances, and appeals in the appropriate tracking system using the appropriate codes. Following are the data elements to be captured for all inquiries, complaints, grievances, and appeals.

****Instances where an inquiry, complaint, grievance, or appeal involves an imminent and serious threat to the health of the patient shall be processed in accordance with UNICARE Dental Services' Expedited Review Process which complies with applicable regulatory requirements.***

IMPORTANT

The insured has the right to file a complaint with the Department of Commerce at any time during the complaint and appeal process, or to contact the Department of Commerce with questions or concerns regarding coverage under the Group Policy.

By phone: Minnesota Department of Commerce
1-800-657-3602

In writing: Minnesota Department of Commerce
133 East 7th Street
St. Paul, Minnesota 55101

Data Capture

- Name(s) of the insured
- Name of patient
- Address
- Telephone number
- Group number
- Name (or initials) of individual receiving information
- Date received
- Type
- Summary of issue, including who or what complaint / grievance is about
- Source
- Reason
- Line of business, product line and service
- Disposition
- Status, e.g., forwarded to another entity, waiting for internal review
- Resolution
- Closed date

UNICARE will track inquiries, complaints, grievances, and appeals for reporting to regulatory entities requiring such reporting.

Tier I:

All verbal or written inquiries made by insureds with respect to the provision of services by UNICARE are considered inquiries initially and categorized as Tier I issues.

Under the Tier I process, the Dental Services associate reviews the inquiry. If the determination by UNICARE made as a result of the Tier I review is satisfactory to the person requesting such review, the issue is considered closed and is not logged as a part of the complaint / grievance and appeals process.

If UNICARE's Tier I review determination is not satisfactory to the insured requesting such review, then the associate will inform the insured that to initiate a complaint / grievance, the complaint / grievance request must be in writing. The CSR will provide the insured with the necessary form(s) to be mailed to:

Name: Barbara Chipres
Title: Manager, Compliance
Address: UNICARE (Dental Services)
5171 Verdugo Way
Camarillo, CA 93012
Phone: (800)627-0004
Fax: (805)384-7531

An inquiry not resolved to the insured's satisfaction under Tier I and subsequently submitted to UNICARE in writing as a complaint or grievance may advance to the Tier II or Tier III level.

Tier II

Upon receipt of a grievance, UNICARE will:

- Date stamp the letter and log the grievance in the appropriate system
- Assign an individual to manage the grievance
- Acknowledge receipt of a grievance in writing within applicable state regulatory requirements to the insured and other parties deemed appropriate by Dental Services; and will advise appropriate individuals that the:
 - Investigation of the grievance should be completed within thirty (30) working days after receipt of the request, unless additional information is required
 - Insured must cooperate with UNICARE in the investigation
 - Insured will be notified of UNICARE's determination in accordance with applicable state regulatory requirements of the completion of the investigation
 - Review is being managed by a designated individual and any questions should be directed to this individual (provide name and telephone number of the individual to requester in the acknowledgment letter).

UNICARE will contact the insured via telephone or in writing if additional information is required in order to process the grievance. Such contact will include providing the insured with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information form).

If the insured does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the thirty (30) day investigation, UNICARE will inform the insured that the requested information has to be provided or the grievance will be closed.

UNICARE will close the grievance file if requested information is not received within ten (10) working days after the 30 day period and will notify the insured of closure due to failure to respond.

If additional time is needed to complete the investigation, UNICARE will contact the insured and other parties as deemed appropriate by Dental Services and inform them of the reason the additional time is required.

Once the grievance review has been completed, UNICARE will communicate in writing the review determination and supporting information to the insured (and other parties as deemed appropriate by Dental Services). Such communication may include the following information as is appropriate and/or required by regulatory entities:

- Statement of the reviewer's understanding of the reason for the grievance
- Qualifications of the responsible professional
- Reviewer's decision
- Reference to the Plan provision supporting the decision
- Reference to any other evidence or documentation supporting the decision
- Statement indicating the insured's right to a Tier III review and the procedure to do so

If the resolution of the grievance is not satisfactory to the insured, the insured will be informed of the right to appeal the grievance decision to Tier III, the third level of review.

All information related to the grievance will be maintained for a period of seven (7) years.

A written request by an insured for reversal of a prior communicated UNICARE decision or non-responsiveness is an appeal and advances to Tier III.

Tier III:

A Tier III appeal will be submitted to an appeal panel. The appeal panel may consist of persons not previously involved with the matter, persons not employed by UNICARE and who do not have a financial interest in the appeal.

Upon receipt of an appeal, UNICARE will:

- Date stamp the letter and log the appeal in the appropriate system
- Assign an individual to manage the appeal
- Acknowledge receipt of an appeal in writing within applicable state regulatory requirements to the insured and other parties deemed appropriate by Dental Services
- Notify the member within applicable state regulatory requirements of the appeal committee meeting
- Advise appropriate individuals that the:
 - Investigation of the appeal should be completed within sixty (60) working days
 - Insured must cooperate with UNICARE in the investigation
 - Insured will be notified of UNICARE's determination within five (5) working days of the completion of the investigation

- Insured has specific rights and responsibilities (including rights to information, attend the appeal committee meeting, submit new information, to be represented in person)
- Review is being managed by a designated individual and any questions should be directed to this individual (the name and telephone number of the individual is provided to the requester in acknowledgment letter)

UNICARE, in communicating in writing a specific decision to the insured, may include the following information as is necessary or required by applicable state or federal regulation:

- Statement of the reviewer's understanding of the reasons for the appeal
- Qualifications of the responsible professional, including licensure of panel members
- Reviewer's decision, i.e., recommendation of review panel
- UNICARE's decision and rationale if different from panel's recommendation
- Reference to the Plan provision supporting the decision
- Reference to any other evidence or documentation supporting the decision
- Statement indicating the insured's right to appeal the decision to the Plan Administrator or appropriate state regulator, including the telephone number and address of the commissioner
- Statement concerning right of insured under ERISA Section 502(a) with respect to civil action
- Statement indicating the decision is UNICARE's final determination

UNICARE will contact the insured either by telephone or in writing if additional information is required in order to process the appeal. Such contact will include providing the insured with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information).

If the insured does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the sixty (60) day investigation, UNICARE will inform the insured that the requested information has to be provided or the appeal will be closed.

UNICARE will close the appeal file if requested information is not received within ten (10) working days after the sixty 60-day period and will notify the insured of closure due to failure to respond.

All information related to the appeal will be internally reviewed by a committee consisting of individuals who were not involved in the decision being appealed.

All information pertaining to the appeal will be filed and maintained for a period of seven (7) years.

External Review

If the complaint is concerning an adverse determination as defined above, the insured has a right to request an independent external review. The insured must complete an application along with a \$25 filing fee and submit the request to the address shown below.

Upon receiving a request for an external review, the external review entity will request information from both the insured and the insurer in order to complete their review. This information must be provided within 10 days following the request.

To request an independent external review, the insured or their representative should contact:

External Appeals Process
State of Minnesota
Department of Commerce
133 East 7th Street
St. Paul, Minnesota 55101
1-800-657-3602 or 651-296-2488

Claim Administration provided by: WellPoint Dental Services, a division of UNICARE Life & Health Insurance Company.



ReliaStar Life Insurance Company

CERTIFICATE BOOKLET RIDER

Applicable to Minnesota Residents

Minnesota law requires the following benefits be provided to Minnesota residents.

I. TMJ Coverage

1. The following provision is added to your certificate:

Coverage for surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder is included as a covered benefit under Type III expenses, subject to the plan deductibles and maximums listed on the Schedule of Benefits. Treatment for TMJ and craniomandibular disorders must be provided by a doctor or dentist.

2. The following exclusion is deleted if it appears in your certificate:

- Treatment for temporomandibular joint dysfunction (TMJ).

II. Definitions

1. If your plan does not cover domestic partners, the following definition of Dependent applies.

Dependent -

- your lawful spouse.
- your unmarried child less than 19 years of age.
- your unmarried child 19 years of age but less than 25 years of age who is a student dependent.
- your grandchild who resides with you continuously from birth and is your dependent.

The term "dependent" does not include -

- a spouse, child or grandchild living outside the United States.

- a spouse, child or grandchild eligible for Employee's Insurance under the Group Policy.
- a spouse, child or grandchild on active military duty.
- a parent of you or your spouse.

2. If your plan does cover domestic partners and domestic partners children, the following definition of Dependent applies.

Dependent -

- your lawful spouse.
- your domestic partner, as defined
- your unmarried child or domestic partner's child less than 19 years of age.
- your unmarried child or domestic partner's child 19 years of age but less than 25 years of age who is a student dependent.
- your grandchild who resides with you continuously from birth and is your dependent.

The term "dependent" does not include -

- a spouse, domestic partner, grandchild or child or domestic partner's child living outside the United States.
- a spouse, domestic partner, grandchild or child or domestic partner's child eligible for Employee's Insurance under the Group Policy.
- a spouse, domestic partner, grandchild or child or domestic partner's child on active military duty.
- a parent of you or your spouse or domestic partner.

3. **Student Dependent** - a dependent who does not have a regular full-time job and is a full-time student physically attending classes at a school with a regular teaching staff, curriculum and student body.

ReliaStar Life considers full-time to be the number of credits or courses required for full-time students by the school your dependent is attending.

A full-time student includes any student who by reason of illness, injury, or physical or mental disability, as documented by a doctor, is unable to carry what the school considers a full-time course load so long as the student's course load is at least 60% of what otherwise is considered by the school to be a full-time course load.

All other provisions of your certificate remain unchanged.

ReliaStar Life Insurance Company

CERTIFICATE BOOKLET RIDER

Applicable to Montana Residents

The **CLAIM PROCEDURES** section of your group life insurance certificate is revised to add the following provision:

Benefit Payments

Benefits under the Group Policy are paid when proof of loss is received.

For Life Insurance, benefits payable due to death will be paid within 60 days of the date ReliaStar Life receives proof of death. If payment is made after the first 30 days, ReliaStar Life will include interest from the 30th day until the date of payment. The interest rate will equal the **greater** of the following –

- The discount rate on 90-day commercial paper in effect at the federal reserve bank in the ninth federal reserve district on the date proof of death is received.
- ReliaStar Life's minimum interest rate payable on death claims on the date proof of death is received.

The **GENERAL PROVISIONS** section of your group life insurance certificate is revised to add the following provisions:

The Group Policy also has a 2 year contestable period starting from the Effective Date of the Group Policy. After the Group Policy has been in force for 2 years from the Effective Date, ReliaStar Life can not contest the validity of the Group Policy except for nonpayment of premium.

Grace Period

If a premium is not paid by its due date, ReliaStar Life allows 31 days from the due date in which to pay it. ReliaStar Life calls this the grace period. Full payment must be received by the 31st day. If ReliaStar Life receives payment during the grace period, coverage under the Group Policy stays in force. If ReliaStar Life receives written notice of termination during the grace period, premium payment is required for any period that coverage under the Group Policy was in force during the grace period.

Representations Not Warranties

A copy of the Policyholder's application, if any, is attached to the Group Policy. Unless fraudulent, all statements made by the Policyholder or by you are considered representations and not warranties. No statement can be used to void the Group Policy or be used in ReliaStar Life's defense if ReliaStar Life refuses to pay a claim, unless a copy of the statement is furnished to the Policyholder, you or your beneficiary, as applicable.

Misstatement of Age

If your (or your dependent's, if your certificate includes Dependent's Life Insurance) age is misstated, ReliaStar Life adjusts the premium according to the correct age. The amount of insurance provided is not affected.

Conformity with Montana Statutes

The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which you reside on or after the effective date of your coverage under the Group Policy.

The **CONVERSION RIGHTS** section of your group life insurance certificate for you (and your insured dependents, if your certificate includes Dependent's Life Insurance) is revised as indicated below.

Under **Conditions for Conversion**, the condition related to change, cancellation or termination of the Group Policy is replaced by the following:

- The Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 3 years in a row.

The following provision is added:

If you or your insured dependent are not given written notice of this conversion right within 16 days after any part of this insurance stops, you or your insured dependent will have more time to apply and pay the first premium for the individual policy. This additional time period will end 15 days after you or your insured dependent are given written notice of this conversion right. In no event will the additional time period extend for more than 91 days after any part of your Life Insurance or Dependent's Life Insurance stops.

The provision entitled **Amount of Conversion Coverage** is replaced by the following:

Amount of Conversion Coverage

If your or your insured dependent's Life Insurance is changed or cancelled because the Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 3 years in a row, the amount of the individual policy is limited to the lesser of –

- \$10,000, or
- the amount of your or your insured dependent's Life Insurance which stops, minus the amount of other group insurance for which you or your insured dependent become eligible within 31 days of the date your or your insured dependent's insurance stops.

If your or your insured dependent's Life Insurance stops for any reason other than the above, the amount of your or your insured dependent's individual policy may be any amount up to the amount of your or your or your insured dependent's Life Insurance that stopped.

R-08187a

National Dental Grievance, Complaints, Appeals Process

Application: All UNICARE business.

Definitions:

Inquiries* and Complaints* are questions or concerns from customers regarding any aspect of UNICARE's operation which may include (but are not limited to):

- Claims payment, handling or reimbursement for dental care services
- Matters pertaining to the contractual relationship between a customer and UNICARE

Grievances* are a customer's dissatisfaction with:

- The availability, accessibility, or delivery of services by network providers
- The response to a customer's concern

Appeals* are requests by customers for reconsideration of a claim determination or pre-authorization made by UNICARE in accordance with the client's plan with respect to benefits payable under the plan. Appeals are written requests for a second review.

Customer is an individual or entity (or the authorized representative of an individual or entity) to whom UNICARE provides services. Specifically, this definition of customer includes, but is not limited to, clients, patients, enrollees, dental care providers or provider facilities (or their authorized representative).

Purpose: To provide a fair and reasonable process for handling customer inquiries, complaints grievances and appeals.

Overview: The following guidelines are to set forth the UNICARE policy and procedures for resolution of complaints, grievances and appeals; and are subject to all state and federal laws and specific plan provisions.

UNICARE Dental Services may receive inquiries, complaints, grievances and appeals either by telephone through the Customer Service Unit (CSU) or by mail to the Technical Support Unit (TSU). Dental Services Associates will record all inquiries, complaints, grievances, and appeals in the appropriate tracking system using the appropriate codes. Following are the data elements to be captured for all inquiries, complaints, grievances, and appeals.

****Instances where an inquiry, complaint, grievance, or appeal involves an imminent and serious threat to the health of the patient shall be processed in accordance with UNICARE Dental Services' Expedited Review Process which complies with applicable regulatory requirements.***

Data Capture

- Name(s) of the customer
- Name of patient
- Address
- Telephone number
- Group number
- Name (or initials) of individual receiving information
- Date received
- Type
- Summary of issue, including who or what complaint / grievance is about
- Source
- Reason
- Line of business, product line and service
- Disposition
- Status, e.g., forwarded to another entity, waiting for internal review
- Resolution
- Closed date

UNICARE will track inquiries, complaints, grievances, and appeals for reporting to regulatory entities requiring such reporting.

Tier I:

All verbal or written inquiries made by customers with respect to the provision of services by UNICARE are considered inquiries initially and categorized as Tier I issues.

Under the Tier I process, the Dental Services associate reviews the inquiry. If the determination by UNICARE made as a result of the Tier I review is satisfactory to the person requesting such review, the issue is considered closed and is not logged as a part of the complaint / grievance and appeals process.

If UNICARE's Tier I review determination is not satisfactory to the customer requesting such review, then the associate will inform the customer that to initiate a complaint / grievance, the complaint / grievance request must be in writing. The CSR will provide the customer with the necessary form(s) and address for mailing.

Name: Barbara Chipres
Title: Manager, Compliance
Address: UNICARE (Dental Services)
5171 Verdugo Way
Camarillo, CA 93012
Phone: (800)627-0004
Fax: (805)384-7531

An inquiry not resolved to the customer's satisfaction under Tier I and subsequently submitted to UNICARE in writing as a complaint or grievance may advance to the Tier II or Tier III level.

Tier II

Upon receipt of a grievance, UNICARE will:

- Date stamp the letter and log the grievance in the appropriate system
- Assign an individual to manage the grievance
- Acknowledge receipt of a grievance in writing within applicable state regulatory requirements to the customer and other parties deemed appropriate by Dental Services; and will advise appropriate individuals that the:
 - Investigation of the grievance should be completed within thirty (30) working days after receipt of the request, unless additional information is required
 - Customer must cooperate with UNICARE in the investigation
 - Customer will be notified of UNICARE's determination in accordance with applicable state regulatory requirements of the completion of the investigation
 - Review is being managed by a designated individual and any questions should be directed to this individual (provide name and telephone number of the individual to requester in the acknowledgment letter).

UNICARE will contact the customer via telephone or in writing if additional information is required in order to process the grievance. Such contact will include providing the customer with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information form).

If the customer does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the thirty (30) day investigation, UNICARE will inform the customer that the requested information has to be provided or the grievance will be closed.

UNICARE will close the grievance file if requested information is not received within ten (10) working days after the 30 day period and will notify the customer of closure due to failure to respond.

If additional time is needed to complete the investigation, UNICARE will contact the customer and other parties as deemed appropriate by Dental Services and inform them of the reason the additional time is required.

Once the grievance review has been completed, UNICARE will communicate in writing the review determination and supporting information to the customer (and other parties as deemed appropriate by Dental Services). Such communication may include the following information as is appropriate and/or required by regulatory entities:

- Statement of the reviewer's understanding of the reason for the grievance
- Qualifications of the responsible professional
- Reviewer's decision

- Reference to the Plan provision supporting the decision
- Reference to any other evidence or documentation supporting the decision
- Statement indicating the customer's right to a Tier III review and the procedure to do so

If the resolution of the grievance is not satisfactory to the customer, the customer will be informed of the right to appeal the grievance decision to Tier III, the third level of review.

All information related to the grievance will be maintained for a period of seven (7) years.

A written request by a customer for reversal of a prior communicated UNICARE decision or non-responsiveness is an appeal and advances to Tier III.

Tier III:

A Tier III appeal will be submitted to an appeal panel. The appeal panel may consist of persons not previously involved with the matter, persons not employed by UNICARE and who do not have a financial interest in the appeal.

Upon receipt of an appeal, UNICARE will:

- Date stamp the letter and log the appeal in the appropriate system
- Assign an individual to manage the appeal
- Acknowledge receipt of an appeal in writing within applicable state regulatory requirements to the customer and other parties deemed appropriate by Dental Services
- Notify the member within applicable state regulatory requirements of the appeal committee meeting
- Advise appropriate individuals that the:
 - Investigation of the appeal should be completed within sixty (60) working days
 - Customer must cooperate with UNICARE in the investigation
 - Customer will be notified of UNICARE's determination within five (5) working days of the completion of the investigation
 - Customer has specific rights and responsibilities (including rights to information, attend the appeal committee meeting, submit new information, to be represented in person)
 - Review is being managed by a designated individual and any questions should be directed to this individual (the name and telephone number of the individual is provided to the requester in acknowledgment letter)

UNICARE, in communicating in writing a specific decision to the customer, may include the following information as is necessary or required by applicable state or federal regulation:

- Statement of the reviewer's understanding of the reasons for the appeal
- Qualifications of the responsible professional, including licensure of panel members
- Reviewer's decision, i.e., recommendation of review panel
- UNICARE's decision and rationale if different from panel's recommendation

- Reference to the Plan provision supporting the decision
- Reference to any other evidence or documentation supporting the decision
- Statement indicating the customer's right to appeal the decision to the Plan Administrator or appropriate state regulator, including the telephone number and address of the commissioner
- Statement concerning right of customer under ERISA Section 502(a) with respect to civil action
- Statement indicating the decision is UNICARE's final determination

UNICARE will contact the customer either by telephone or in writing if additional information is required in order to process the appeal. Such contact will include providing the customer with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information).

If the customer does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the sixty (60) day investigation, UNICARE will inform the customer that the requested information has to be provided or the appeal will be closed.

UNICARE will close the appeal file if requested information is not received within ten (10) working days after the sixty 60-day period and will notify the customer of closure due to failure to respond.

All information related to the appeal will be internally reviewed by a committee consisting of individuals who were not involved in the decision being appealed.

All information pertaining to the appeal will be filed and maintained for a period of seven (7) years.

Claim Administration provided by: WellPoint Dental Services, a division of UNICARE Life & Health Insurance Company.

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to New Mexico Residents

New Mexico law requires the following benefits be provided to New Mexico residents.

If dependents are covered, the definition of Dependent* is replaced by the following:

Dependent -

- your legal spouse.
- your unmarried child less than 25 years of age.

The term "dependent" does not include -

- a spouse or child living outside the United States.
- a spouse or child eligible for Employee's Insurance under the Group Policy.
- a spouse or child on active military duty.
- a parent of you or your spouse.

*If your plan covers domestic partners, the definition of dependent also includes domestic partners.

All other provisions of the certificate remain unchanged.

OKLAHOMA MANDATORY ENDORSEMENT

This endorsement is part of the policy and/or certificate to which it is attached.

The full name and home office address of the company underwriting insurance coverage under the Group Policy is:

ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, Minnesota 55401

Oklahoma law requires the following statement:

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

ReliaStar Life Insurance Company

R-08231



ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, Minnesota 55401

OREGON ACCELERATED BENEFIT SUMMARY

The Group Policy provides an accelerated benefit if the eligible insured is diagnosed with a terminal condition. This provides payment of a percentage of the death benefit otherwise payable, as noted in the certificate, while the insured is living. The accelerated benefit payment reduces the amount of Life Insurance payable at death.

“Terminal condition” means an injury or sickness which is expected to result in the insured’s death within a time period specified in the certificate, and from which there is no reasonable chance of recovery.

The cost of the accelerated benefit is incorporated into the cost of Life Insurance and is not a separately identifiable premium.

Following payment of accelerated benefits, future Life Insurance premiums for the insured’s coverage will be waived under the Waiver of Life Insurance Premium Disability Benefit.

Please refer to the certificate for the provision(s) that relate to this Group Policy.

Receipt of accelerated benefits may be taxable and the insured should seek assistance from a personal tax advisor prior to submitting a claim.



Grievance Procedure for Insured & ASO Cases

Title: Grievance Procedure for South Dakota	Policy No.
Distribution: Quality Management, Customer Service, Technical Services Unit	Version No. Date:
Authorization: Legislative Compliance Committee	Effective Date: 7/1/04

Supersedes: Grievance Procedure for South Dakota (form R-08236SD)

1. BACKGROUND OR SCOPE

To comply with statutory and regulatory requirements, WellPoint Dental Services, a division of UNICARE Life & Health Insurance Company (WellPoint) has updated the grievance/appeal process used in South Dakota. This update is designed to comply with U. S. Department of Labor’s new ERISA Claims Regulations, 29 Code of Federal Regulations (C.F.R.) § 2560.503-1 and with South Dakota’s laws/regulations regarding grievances.

2. PURPOSE

To ensure consistency and timeliness in responding to grievances including the review processes required by law, and to provide appropriate notification on Insured and Administrative Services Only (ASO) business.

3. POLICY STATEMENT

WellPoint recognizes the claimant’s right to file a written grievance. WellPoint will process grievances in a timely manner and provide appropriate notification in accordance with all state and federal regulations.

4. DEFINITIONS

Grievance means a written complaint submitted by or on behalf of a covered person regarding any of the following:

- Availability, delivery or quality of health care services;
- Claims payment, handling, or reimbursement for health care services; or
- Any other matter pertaining to the contractual relationship between a covered person and the health carrier.



Grievance Procedure for Insured & ASO Cases

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Adverse determination means any of the following:

- 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 the covered person’s eligibility to participate in a plan;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; or
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Health care services means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Managed care plan means a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

- Arrangements with selected providers to furnish health care services;
- Explicit standards for the selection of participating providers; or
- Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.



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5. FIRST LEVEL REVIEW PROCEDURE

Within one hundred and eighty (180) days after the claimant receives notice of an adverse determination, the claimant may file a Grievance requesting a first level review of the adverse determination.

Upon receipt of a Grievance involving an adverse determination, WellPoint will:

- Date stamp the letter and log the Grievance in the appropriate system;
- Assign an individual to manage the first level review of the Grievance;
- Appoint a person or group to review the grievance. This must include a dentist reviewer who has not been involved in the initial adverse determination;
- Acknowledge receipt of the Grievance in writing within three (3) working days after receiving the Grievance to the claimant; and
- Advise the claimant that the:
 - Investigation of the Grievance will be completed and a written decision will be issued within sixty (60) working days after receipt of the request;
 - Claimant must cooperate with WellPoint in the investigation;
 - Review is being managed by a designated individual and any questions should be directed to this individual (provide name, address and telephone number of the individual to requester in the acknowledgment letter);
 - Claimant is entitled to submit written material for the designated individual to consider when conducting the review, but the claimant may not attend the review; and
 - Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.



Grievance Procedure for Insured & ASO Cases

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WellPoint will contact the claimant via telephone or in writing if additional information is required in order to process the Grievance. Such contact will include providing the claimant with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information form).

If the claimant does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the sixty (60) day investigation, WellPoint will make a determination based on the information available and notify the claimant accordingly.

Once the Grievance review has been completed, WellPoint will communicate in writing the review determination and supporting information to the claimant. Such communication will include all of the following information:

- Titles and qualifying credentials of the reviewer(s);
- Statement of the reviewer’s understanding of the Grievance;
- Reviewer’s decision in clear terms;
- The contract basis or medical rationale in sufficient detail for the claimant to respond further to the position;
- Reference to any other evidence or documentation supporting the decision;
- If the review decision involves an adverse determination:
 - The specific reason(s) for the adverse determination;
 - Reference to the specific plan provisions on which the determination is based;
 - A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;



Grievance Procedure for Insured & ASO Cases

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- If applicable to the adverse determination decision, either the specific internal rule, guideline, protocol, or other similar criterion relied upon to make the adverse determination, or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request (instructions must also be included for requesting this copy);
- If the adverse determination decision is based on a medical necessity or experimental or investigational treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that an explanation will be provided to the claimant free of charge upon request (instructions must also be included for requesting this written explanation);
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures;
- A statement of the claimant's right to bring an action under ERISA (if applicable) or the right to bring a civil action in a court of competent jurisdiction; and
- Notice of the claimant's right, at any time, to contact the South Dakota Division of Insurance (include the telephone number and address):
 - South Dakota Division of Insurance
 - 445 E. Capitol Avenue
 - Pierre, SD 57501
 - (605) 773-3563



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6. STANDARD REVIEW PROCEDURE

This review procedure only applies to a Grievance that does not involve an adverse determination.

Upon receipt of a Grievance that does not involve an adverse determination, WellPoint will:

- Date stamp the letter and log the Grievance in the appropriate system;
- Assign an individual to manage the Grievance. This individual will be someone other than the person who handled the matter that is the subject of the Grievance;
- Acknowledge receipt of the Grievance in writing within three (3) working days after receiving the Grievance to the claimant and other parties deemed appropriate by WellPoint; and
- Advise the claimant and other appropriate individuals that the:
 - Investigation of the Grievance will be completed and a written decision will be issued within twenty (20) working days after receipt of the request. If, due to circumstances beyond WellPoint’s control, a decision can not be made within twenty (20) days, then WellPoint will provide written notice on or before the twentieth (20th) working day to the claimant of the extension and the reasons for the delay, in which case WellPoint may take up to 10 additional working days to complete the investigation and issue the written decision;
 - Claimant must cooperate with WellPoint in the investigation;
 - Review is being managed by a designated individual and any questions should be directed to this individual (provide name, address and telephone number of the individual to requester in the acknowledgment letter);



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Distribution: Quality Management, Customer Service, Technical Services Unit	Version No. Date:
Authorization: Legislative Compliance Committee	Effective Date: 7/1/04

- Claimant is entitled to submit written material for the designated individual to consider when conducting the review, but the claimant may not attend the review; and
- If the Grievance requires review of services authorized to be provided or treatment which has been provided by a practitioner, the review will include a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

WellPoint will contact the claimant via telephone or in writing if additional information is required in order to process the Grievance. Such contact will include providing the claimant with the necessary form(s) and/or instructions for obtaining the additional information (e.g. an authorization for release of information form).

If the claimant does not fulfill their responsibilities related to the investigation (e.g., has not provided sufficient requested information, a signed authorization for release of information, etc.) during the twenty (20) day investigation, WellPoint will make a determination based on the information available and notify the claimant accordingly.

Once the Grievance review has been completed, WellPoint will communicate in writing the review determination and supporting information to the claimant. Such communication will include all of the following information:

- Titles and qualifying credentials of the reviewer(s);
- Statement of the reviewer’s understanding of the Grievance;
- Reviewer’s decision in clear terms;
- Reference to the specific plan provisions on which the benefit determination is based;
- Reference to any other evidence or documentation supporting the decision;



Grievance Procedure for Insured & ASO Cases

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- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures;
- A statement of the claimant's right to bring an action under ERISA (if applicable); and
- Notice of the claimant's right, at any time, to contact the South Dakota Division of Insurance (include the telephone number and address):
 South Dakota Division of Insurance
 445 E. Capitol Avenue
 Pierre, SD 57501
 (605) 773-3563

7. VOLUNTARY REVIEW PROCEDURE

Managed care plans must provide an additional voluntary review process for claimants who are dissatisfied with the first level review or standard review decision. This does not apply to indemnity plans.

Upon receipt of a request for additional voluntary review, WellPoint will:

- Date stamp the letter and log the request in the appropriate system.
- Appoint a review panel to review the request. A person who was involved in the first level or standard review decision may be a member of the panel or appear before the panel to present information or answer questions. A majority of the panel must be comprised of people who were not involved in the first level or standard review decision. For an additional voluntary review of a first level review decision only, a majority of the panel must be comprised of health care professionals who have appropriate expertise [if a reviewing health care professional without the



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required expertise is not reasonably available and there has been a denial of a health care service, the reviewing health care professional is only ineligible to review decisions if the professional is both a provider in the claimant's health plan and has a financial interest in the outcome of the review];

- Acknowledge receipt of the request in writing within five (5) working days after receiving the request to the claimant and other parties deemed appropriate by WellPoint; and
- Advise the claimant and other appropriate individuals that the:
 - Claimant may receive from WellPoint, upon request, copies of all documents, records, and other information that is not confidential or privileged relevant to the request;
 - Claimant is entitled to submit written comments, documents, records, and other material relating to the request for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
 - Claimant may request the opportunity to appear in person before the review panel within five (5) working days of receiving the notice from WellPoint;
 - Claimant is entitled to be assisted or represented by an individual of their choice; and
 - If the claimant attends the review meeting, the claimant is entitled to ask questions of any person on the review panel.

If the claimant requests the opportunity to appear in person before the review panel, then all of the following apply:

- Review panel will schedule and hold a review meeting within forty-five (45) working days after receipt of the request;
- Claimant must be notified in writing at least fifteen (15) working days in advance of the date of the review meeting;



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- WellPoint may not unreasonably deny a request for postponement of the review made by the claimant;
- Review meeting must be held during regular business hours at a location reasonably accessible to the claimant;
- In any case in which a face-to-face meeting is not practical for geographic reasons, WellPoint must offer the claimant the opportunity to communicate with the review panel, at WellPoint’s expense, by conference call, video conferencing, or other appropriate technology;
- If WellPoint chooses to have an attorney present at the review, WellPoint must notify the claimant in writing at least fifteen (15) working days in advance of the date of the review meeting that an attorney will be present and that the claimant may wish to obtain legal representation of their own; and
- Within five (5) working days of completing the review meeting, the review panel must issue a written decision to the claimant.

If the claimant does not request the opportunity to appear in person before the review panel within five (5) working days after receipt of notice of the claimant’s right to appear, then the review panel must issue a decision and notify the claimant of the decision in writing or electronically, within forty-five (45) working days after the earlier of:

- The date the claimant notifies WellPoint of the claimant’s decision not to request the opportunity to appear in person before the review panel; or
- The date on which the claimant’s opportunity to request to appear in person before the review panel expires.

The review panel’s written decision must include all of the following:

- Titles and qualifying credentials of the members of the review panel;
- Statement of the review panel’s understanding of the nature of the Grievance and all pertinent facts;



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- Rationale for the review panel’s decision;
- Reference to evidence or documentation considered by the review panel in making the decision;
- If the Grievance involves an adverse determination, the instructions for requesting a statement of the clinical rationale, including the clinical review criteria used to make the determination;
- A statement of the claimant's right to bring an action under ERISA (if applicable); and
- Notice of the claimant’s right, at any time, to contact the South Dakota Division of Insurance (include the telephone number and address):

South Dakota Division of Insurance
445 E. Capitol Avenue
Pierre, SD 57501
(605) 773-3563

The decision of the review panel is legally binding on the health carrier.

8. MONITORING/REPORTING

WellPoint will produce and periodically monitor Grievance Reports.

All information related to each Grievance will be maintained for a period of five (5) years.

9. RESPONSIBILITIES

Reporting will be provided to the WellPoint Quality Assurance Committee quarterly. The committee has the responsibility to insure compliance with state specific and federal standards.

10. REFERENCE SOURCES

ERISA Claim Procedures (29 CFR Part 2560.503-1)
WellPoint Benefits Administration Policy #30
South Dakota Insurance Code chapter 58-17C.

**TEXAS RESIDENTS:
IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call ReliaStar Life's toll-free telephone number for information or to make a complaint at 1-800-328-4090.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:

P. O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact ReliaStar Life first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

R-07488

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de ReliaStar Life para informacion o para someter una queja al 1-800-328-4090

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P. O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con ReliaStar Life primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documents adjunto.

R-07488

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to Texas Residents

Texas law limits the amount of life insurance that can be provided to employees and dependents of employees. The life Insurance amounts show in your certificate booklet are reduced if the amounts are greater than allowed under Texas law, as described below:

An employee's amount of life insurance is limited to the greater or \$250,000 or 7 times (700%) your yearly earnings. This maximum applies to the total of all group life coverage issued to the employee through the Group Policyholder, including any coverage provided by other insurers.

An employee's amount of dependent life insurance, if any, is limited to 50% of the amount of employee life insurance.

RELIASTAR LIFE INSURANCE COMPANY

Home Office: Minneapolis, Minnesota

Texas Accelerated Death Benefit Disclosure Notice:

The accelerated death benefit under this Group Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the accelerated death benefit qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive accelerated benefits excludable from income under federal law.

Receipt of accelerated death benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

R-08121a

RELISTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to Texas Residents

Texas law mandates the following definitions apply to Texas residents.

If dependents are covered, the following definitions apply:

Child-

- your natural or adopted child.
- Your grandchild who, at the time you apply for coverage for your grandchild, is your dependent for federal income tax purposes.
- a child who is placed in your home for purposes of adoption, or for whom you have filed suit for adoption.
- your stepchild.
- a child who is primarily dependent on you for support and lives with you in a permanent parent-child relationship, and who is your foster child or a child for whom you are a legal guardian.
- a child for whom you are responsible for medical support under the terms of an order issued under the Texas Family Code or enforceable by a Texas court.

Dependent-

- your legal spouse.
 - your unmarried child less than 25 years of age.
- The term "dependent" does not include-
- a spouse or child living outside the United States.
 - a spouse or child eligible for Employee's Insurance under the Group Policy.
 - a spouse or child on active military duty.
 - a parent of you or your spouse.

R-08204a

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If any insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, disability (health) and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's guaranty association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of ULHIGA, including limited health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 --- whichever is lower. Other caps also apply:

- \$200,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$200,000 in disability (health) insurance benefits.
- \$200,000 in annuity benefits --- if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply.)
- Interest rates on some policies may be adjusted downward.

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DISCLAIMER

PLEASE READ CAREFULLY:

COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A CHAPTER 28.

COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.

INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.

Utah Life and Health Insurance Guaranty Association
955 E. Pioneer Road
Draper, Utah 84020

Utah Insurance Department
STATE OFFICE BUILDING, ROOM 3110
Salt Lake City, Utah 84114

110928

08-20-01

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to Washington Residents

Washington law requires the following benefits be provided to Washington residents.

I. If your certificate contains an Accidental Death & Dismemberment benefit and/or an Accidental Death & Dismemberment benefit for dependents, the following provision applies:

Accidental Death & Dismemberment (AD&D) Insurance

ReliaStar Life pays this benefit if you or your insured dependent lose your or your insured dependent's life, limb or sight due to an accident.

All of the following conditions must be met:

- You or your insured dependent are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 365 days of the date of the accident.
- The cause of the loss is not excluded.

All other provisions of the Accidental Death & Dismemberment benefit remain unchanged.

II. If your certificate contains an Accelerated Death benefit, the following applies:

1. NOTE: IF YOU RECEIVE PAYMENT OF ACCELERATED BENEFITS, YOU MAY LOSE YOUR RIGHT TO RECEIVE CERTAIN PUBLIC FUNDS, SUCH AS MEDICARE, MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY, SUPPLEMENTAL SECURITY INCOME (SSI), AND POSSIBLY OTHERS. ALSO, RECEIVING ACCELERATED BENEFITS MAY HAVE TAX CONSEQUENCES FOR YOU. RELIASTAR LIFE CANNOT GIVE YOU ADVICE ABOUT THIS. YOU MAY WISH TO OBTAIN ADVICE FROM A TAX PROFESSIONAL OR AN ATTORNEY BEFORE YOU DECIDE TO RECEIVE ACCELERATED BENEFITS.

THE ACCELERATED BENEFITS ARE NOT INTENDED TO COMPLY WITH 26 U.S.C. 101(G) IN REGARD TO TERMINALLY ILL INSURED. THE ACCELERATED BENEFITS ARE NOT INTENDED TO COMPLY WITH 26 U.S.C. 7702B REGARDING QUALIFIED LONG TERM CARE INSURANCE.

2. Accelerated Death Benefit Exclusions
ReliaStar Life does not pay benefits for a terminal condition if the required Accelerated Death Benefit premium or Life Insurance premium is due and unpaid.

All other provisions of the Accelerated Death remain unchanged.

III. If your certificate includes dependent life coverage, effective September 1, 2001, any dependent life coverage applied for will be limited to 50% of the amount of insurance on the life of the insured employee.

IV. Labor Dispute. If you stop active work because of a labor dispute, you may continue your Life Insurance up to the end of the 6 month period following the date you stop active work. Premiums must be paid.

RELIASTAR LIFE INSURANCE COMPANY

CERTIFICATE BOOKLET RIDER

Applicable to Washington Residents

Washington law requires the following benefits be provided to Washington residents.

If dependents are covered, the following applies to the **Effective Date of Dependent's Insurance** provision.

A newborn dependent is insured from the date of birth and an adopted child from the date of placement if you apply within 60 days following the date of birth or placement.

If you are insured for Dependent's Insurance and you acquire a new dependent by marriage*, you must apply for coverage for the new dependent within 31 days following the event. Coverage for the new dependent is effective on the date of the event.

*If your plan covers domestic partners, reference to marriage also includes domestic partners.

All other provisions of the Effective Date of Dependent's Insurance remain unchanged.

ReliaStar Life Insurance Company

WISCONSIN RESIDENTS:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem:

ReliaStar Life Insurance Company
Minneapolis Regional Office
Route 6410
100 Washington Avenue South, Ste. 730
Minneapolis, MN 55401-1900
612-372-5322

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 (statewide)
608-266-3585 (Madison)