



AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS
Herein referred to as "We, Our, Us, or the Company"
HOME OFFICE: ONE MOODY PLAZA
GALVESTON, TEXAS 77550

INDIANA INTERNAL GRIEVANCE AND EXTERNAL REVIEW PROCEDURE

CAREFULLY READ THE INFORMATION IN THIS SECTION AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH BENEFITS

Definitions

EXTERNAL REVIEW means a review of the Company's grievance resolution by an Independent Review Organization.

GRIEVANCE means any dissatisfaction expressed by You or on Your behalf regarding:

1. An adverse benefit determination that a service or proposed service is not appropriate or Medically Necessary;
2. An adverse benefit determination that a service or proposed service is Experimental or Investigational;
3. The availability of participating providers;
4. The handling of payment of claims for health care services;
5. Matters pertaining to the contractual relationship between a covered individual and the Company or a Group Policyholder and the Company; or
6. The Company's decision to rescind an accident and sickness insurance policy.

You must have a reasonable expectation that action will be taken to resolve or reconsider the matter (as listed in 1-6) that is the subject of the Grievance.

INDEPENDENT REVIEW ORGANIZATION (IRO) means an entity that conducts independent External Reviews of the Company's Grievance determination.

URGENT CARE means medical care or treatment with respect to which the application of time periods for making non-urgent care decisions could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or, in the opinion of a Doctor with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment.

YOU means the Policyholder/Covered Person, or authorized representative, who is making the Grievance.

Internal Grievance Procedure

How to Know When You Can File a Grievance

When We do not authorize or approve a service or pay for a claim, We must notify You of Your right to file a Grievance. This notice will come directly from Us.

Who Can File a Grievance

Either You or Your authorized representative can file a Grievance on Your behalf. If You decide to file a Grievance regarding 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.

How to File a Grievance (the Grievance Procedure)

Contact Us when You:

1. Have a Grievance;
2. Do not understand the reason for an adverse benefit determination;
3. Do not understand why the health care service or treatment resulted in an adverse benefit determination;
4. Do not understand why a request for coverage or health care service or treatment resulted in an adverse benefit determination;
5. Cannot find the applicable provision in Your Policy;
6. Want a copy (free of charge) of the guideline, criteria or clinical rationale that We Used to make Our decision; or
7. Disagree with an adverse benefit determination.

All Grievances must be sent to:

**Health Compliance Department
American National Life Insurance Company of Texas
One Moody Plaza
Galveston, Texas 77550**

Phone: 1-800-899-6510

Fax: 281-535-7150

You must send Your Grievance within 120 days of: (1) the date You receive an adverse benefit determination or (2) the date of the incident giving rise to the Grievance. The Grievance may be made orally or in writing. A Grievance is considered to be filed on the first date it is received, either by telephone or in writing. We will provide a full and fair review of Your Grievance by individuals associated with Us, but who Were not involved in making the initial decision. You may provide Us with additional information that relates to Your claim and You may request copies of information that We have that pertains to Your claims. We will provide You with any new or additional evidence considered, relied upon, or generated by Us in connection with the Grievance. This information will be provided free of charge and as soon as possible and sufficiently in advance of the date on which the notice of any final Grievance determination is provided to give You reasonable opportunity to respond prior to that date.

If a Grievance involves an adverse benefit determination regarding Medical Necessity or treatment is Experimental or Investigational, the Company will appoint a panel that consists of one or more qualified individuals to resolve the Grievance. The individual(s) on the panel will:

1. Have knowledge of the medical condition, procedure, or treatment at issue;
2. Are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the procedures, treatment, or service;
3. Are not involved in the matter giving rise to the Grievance; and
4. Do not have a direct business relationship with the Covered Person or the health care provider who previously recommended the procedure, treatment, or service giving rise to the Grievance.

The Company will resolve the Grievance as expeditiously as possible, but no later than 20 business days after We receive all information reasonably necessary to complete the review. If We are unable to resolve the Grievance within 20 business days, due to circumstances beyond Our control, We will notify You in writing of a 10 business day extension. This notice of extension will be sent to You on or before the 19th business day. In the event of an extension, We will resolve the Grievance within 30 business days from the date You filed the Grievance.

We will send You notice of Our determination within 5 business days after the Grievance is resolved. If You do not receive Our decision within the required time frame, You may be entitled to External Review. Please see the section of this notice titled "External Review Process."

Grievances involving Urgent Care issues will be handled in an expedited manner. We will make Our decision within 24 hours after Our receipt of the Grievance. If You do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Policy, We will notify You as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. We will give You at least 48 hours to provide the specified information. Once You provide the necessary information, We will make Our decision within 24 hours after Our receipt of such information.

We will provide continued coverage pending the outcome of a Grievance.

You may request the diagnosis and treatment codes (and their meanings) for an adverse benefit determination. The Company will not consider a request for such diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review.

If after review of Your Grievance, We uphold Our decision based on a contractual or eligibility issue, We will send You a resolution letter, which will include:

1. Our final Grievance determination form; and
2. A statement of Your right to request an External Review of the Grievance. You may also contact the Indiana Department of Insurance with questions regarding this process at:

**Indiana Department of Insurance
Consumer Service Division
311 W. Washington Street, Suite 300
Indianapolis, Indiana 46204-2787**

External Review Procedure for a Grievance

Who Can Request an External Review

Either You or Your authorized representative can request an External Review on Your behalf.

How to Know When You Can Request an External Review

You may request an External Review for the following Grievance determinations:

1. An adverse determination of appropriateness.
2. An adverse determination of Medical Necessity.
3. A determination that a proposed service is Experimental or Investigational.
4. A denial of coverage based on a waiver.
5. A denial made by the Company regarding a service proposed by the treating health care provider.
6. The Company's decision to rescind an accident and sickness insurance policy.

How to Request an External Review (the External Review Procedure)

You must exhaust Our Internal Grievance Procedure before requesting an External Review. However, if We fail to strictly adhere to Our Internal Grievance Procedure, You are deemed to have exhausted the Internal Grievance Procedure, and may initiate an External Review before completing the Internal Grievance Procedure.

You must submit Your request for External Review within 120 days after receipt of Our notice of the final Grievance determination. You may send Your request for an External Review to:

**Health Compliance Department
American National Life Insurance Company of Texas
One Moody Plaza
Galveston, Texas 77550
Phone: 1-800-899-6510
Fax: 281-535-7150**

We will forward Your request, along with all necessary information, to an IRO certified by the Indiana Department of Insurance.

The IRO shall make a determination to uphold or reverse the Company's appeal resolution within 15 business days after the External Review is filed.

If You have a medical condition that qualifies as Urgent Care, You are entitled to an Expedited External Review. The IRO will provide You and the Company notice of its decision no later than 72 hours after receipt of a request for an Expedited External Review. If the notice is not in writing, the IRO will provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

If at any time during an External Review, You or Your medical Provider submits information to Us that is relevant to Our decision and was not considered by Us previously, We may reconsider Our adverse benefit determination. If We reverse Our decision in Your favor, We will notify You within 15 days after the additional information is submitted. In cases involving Urgent Care, We will notify You within the 72 hours after receipt of the request by the IRO for expedited External Review. If We choose to reconsider, the IRO shall cease the External Review process until the reconsideration is completed. The Company shall respond in the same time frames as under the Internal Appeal Process. If We choose not to reconsider Our decision, We will forward the submitted information to the IRO not more than 2 business days after Our receipt of the information.

The Covered Person will not pay any of the costs associated with the services of an Independent Review Organization. The Company will pay all costs.

This Procedure is effective September 23, 2010, and is signed on behalf of the Company at Galveston, Texas.

A handwritten signature in black ink, appearing to read "J. Michael Flippin". The signature is written in a cursive, flowing style.

Secretary