KENTUCKY
Important Information about your Benefits

Notice of Appeal Procedures

Please refer to your Explanation of Benefits to see the benefit decision for your claim or pre-treatment estimate of benefits. Any Adverse Determinations, as defined below, are made by licensed providers as noted on your Explanation of Benefits. Coverage denials, as defined below, are made under the direction of the Vice President, Group Compliance.

After reading your Explanation of Benefits, you can call us with any questions. You have the right to file an appeal with us if all or part of a benefit determination resulted in denial or reduction of a benefit. The following information describes how you can appeal and how we will process your appeal.

In order to initiate an appeal, during normal business hours, please contact: **Quality Control Unit, PO Box 82657, Lincoln, NE 68501-2657, 877-897-4328 (Toll Free), 402-309-2579(facsimile).**

I. Definitions

"Adverse Determination" means a determination by us that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, or are considered experimental or investigational, as determined by us; and
2. Benefit coverage is therefore denied, reduced, or terminated.

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

"Authorized Person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions.

"Coverage Denial" means our determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's limited health benefit plan.

"Covered Person" means a person covered under our limited health benefit plan.

"Department" means the Kentucky Department of Insurance.

"Expedited Appeal" means that either an appeal of an adverse determination or coverage denial is necessary when in the absence of immediate medical attention could result in any of the following:

1. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

II. Levels of Appeals

A. Internal Appeals Process for Non-Expedited Appeals

The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person within sixty (60) days after receipt of a notice of adverse determination or coverage denial. A provider is not required to obtain written permission from the Covered Person in order to formally request an appeal or file a grievance. We will provide review decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal

appeal. The internal appeal review of an adverse determination shall only be conducted by a licensed provider who did not participate in the initial review and denial. If the case under review requires review of a specialist, then upon request of a covered person, we shall utilize a board eligible or certified provider in the appropriate specialty area to conduct the appeal review. Those portions of the medical records that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers will be given the opportunity to present additional information.

Following the internal appeal review of an adverse decision, we will provide the covered person, authorized person, or provider with an internal appeal determination letter that will include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure, medical license number, and the title of the person making the decision;
3. For pre-treatment estimates, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for filing a complaint with the Department if an adverse determination is upheld by the insurer on internal appeal.

If the covered person, authorized person, or provider has new clinical information regarding the covered person's internal appeal of an adverse decision, he or she may provide that information to us. We will have five (5) business days from the date of the receipt of the information to render a decision based on the new information.

Following the internal appeal of a coverage denial, we will provide the Covered Person, authorized person, or provider acting on behalf of the covered person a letter that will include:

1. The date of the review decision and notification that the decision was made under the direction of the Vice President, Group Compliance.
2. Identification of the schedule of benefits provision or exclusion that demonstrates that coverage is not available;
3. Except for retrospective reviews, a description of alternative benefits, services or supplies that the policy covers, if any; and
4. Instructions for filing a complaint with the Department if a coverage denial is upheld by the insurer on internal appeal.

B. Expedited Internal Appeals

We shall render a decision not later than three (3) business days after receipt of the request for an expedited internal appeal of either an adverse determination or a coverage denial.

You always have the right to contact the Department of Insurance:

Kentucky Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
502-564-3630