

Your Appeal Rights

If you have a question about your claim, we want to help you find answers. Follow these steps when you need information or want to file an appeal about a claim.

You may request more explanation when your claim is denied or the cost of the service you received was not fully covered: Contact us when you:

- Do not understand the reason for the denial;
- Do not understand why the cost was not fully covered;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing information, you or your provider may resubmit the claim with the complete information.

If you are covered by more than one benefit plan, file all claims with each plan.

Appeals: All appeals for claim denial (or any decision that does not cover expenses you believe should have been covered) must be sent to **Grievance and Appeals P.O. Box 14546 Lexington, KY 40512-4546** within 180 days of the date that you receive the denial.² We will provide a full and fair review of your claim. 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 claim. We will notify you of our decision in writing within 30 or 60 days, depending on the appeal process adopted by your plan. Please consult your Benefit Plan Document.