OUR APPEAL PROCEDURES

We carefully review your plan benefits when making claims decisions. If all or part of a claim is denied, you may appeal or submit a written request for a review of our benefit decision within 180 days after receiving our notice of the denial.

Our appeal process is based on timeframes and requirements of ERISA. Individual Policyholders and some group plans are not subject to ERISA, but we will follow either these procedures or state specific appeal rights for you as described further below.

You may send us additional information to support your appeal. You may request copies of any non-privileged information related to your appeal and we will provide it at no charge. You may request the names of any experts we may have consulted who provided advice to us about your claim. If you request any clinical rationale and/or specific clinical guidelines used in the benefit determinations, we will provide them at no charge. If you have a question about a diagnosis, you may need to discuss it with your provider, as diagnostic codes are not submitted to us for dental or routine vision claims.

Appeal reviews will be conducted by the Plan's named fiduciary. Reviews will include any additional information you or your provider submit to us. Appeal reviews will be conducted by someone other than the original reviewer who does not report to that reviewer and who will not consider the original benefit decision. If the denial was based all or partly on a medical judgment, including determinations that a service was considered experimental, investigational, and/or not medically necessary, the appeal review will be conducted by a different qualified health care professional than the one who made the original decision.

If your appeal is about benefits for urgent care, you may call Toll Free at 877-897-4328 and an Expedited Review will be conducted. Notification of our decision will be provided within 72 hours, followed by a confirmation within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to policy coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

For plans subject to ERISA, the Affordable Care Act, or other federal law, you may also have the right to request external review or to seek assistance from the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Contact your plan administrator or consult your benefit documents to determine your plan type.

You may also have additional rights under state laws that provide for special appeal timeframes and external review processes. State specific appeals notices can be found in your plan documents and on our website or you may call us to request a copy. Your state insurance regulatory agency is also always available for assistance.

In any event, if your plan is covered by ERISA, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for review concerning this claim should be sent to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657
877-897-4328 (Toll Free) / Fax 402-309-2579

State laws require insurance carriers to investigate suspected fraudulent activity. If you suspect fraudulent activity or reporting of incorrect information, call our Fraud Hotline @ 800-277-9752.