Notice of Complaint Procedures
In accordance with Ohio Insurance Regulations

Please read this notice carefully along with other information in your Certificate and the Explanation of Benefits sent after a claim is submitted. This notice contains important information about the complaint process available to you. It is sent with benefit denials as well as with your certificate.

You have the right to ask us to assist you in filing a complaint, or to review our decisions involving your requests for benefit estimates, or claims payment. Complaints may be submitted to us in writing, via email or by telephone by you, your designee, or your health care provider to the following address:

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
877-987-4328 (Toll Free)
402-309-2579 (FAX)

If you file a complaint or appeal a benefits decision, we will keep you informed of the status of our review and will respond in no more than 30 calendar days of receipt of necessary information. Complaints involving medical necessity decisions will be reviewed by a clinical peer who was not involved in the initial adverse determination.

The following information will be included in our written decision:

1. A statement of our understanding of the complaint;

2. The principal reasons for the decision, in sufficient detail for your understanding and response, if needed

3. Your rights to file a complaint for review by the Department of Insurance for claims denied based on coverage or contractual matters. Such complaints should be addressed to:

Ohio Department of Insurance
Consumer Services Division
50 West Town Street
3rd Floor, Suite 300
Columbus, OH 43215
(614) 644-2673
1-800-686-1526 (Toll-free in OH)
Complaints may also be filed via the internet at http://insurance.ohio.gov.

External Review is not available for dental or vision claims denied based on medical necessity matters (adverse determinations).

"Adverse Determination" means a determination made by us that a health care service has been reviewed and, based upon the information provided, is not medically necessary or appropriate.

"Complaint" means a written complaint submitted by an insured person or a person, including, but not limited to, a provider, authorized in writing to act on behalf of the insured person regarding benefits or claims payment, handling, or reimbursement for health care services covered under this plan, including adverse determinations.