APPEALS PROCEDURES

If you are currently in the hospital, you, your attending physician or authorized representative may request an expedited appeal if it is determined that you cannot be adequately managed without the current care or treatment. An expedited appeal will be resolved within the timeframes defined by your benefit plan or applicable regulations.

You (Member), the attending physician or authorized representative may request an expedited appeal by calling us at (800) 528-5763 or by writing us at:

Lucet
PO Box 6729
Leawood, KS 66206-0729

If you (Member), the attending physician or authorized representative chooses to appeal a decision to deny payment for services, the 1st level standard appeal may be submitted by calling us at (800) 528-5763, faxed at (816) 237 - 2382 or mailed to the address listed below:

Lucet
PO Box 6729
Leawood, KS 66206-0729

You (Member) have a right to have a representative act on your behalf. All appeals should be directed to the attention of the **Appeals Coordinator**. You have a right to submit written comments, documents or other information relevant to the appeal. Lucet reviews all appeal requests and all previous letters, denials and medical records.

You may request an immediate appeal to an independent review organization if you have a life-threatening condition (Some restrictions may apply depending on plan provisions).

You have the right to an independent review of this decision at no cost to you if you have exhausted the appeal rights available under your health plan. Terms defined by the benefit plan may vary. Please refer to your benefit brochure.

Upon receipt of an appeal request Lucet will (Applicable only to Member Appeals for select plans):

- Acknowledge receipt of your request for an appeal.
- Document the substance of your appeal and action taken.
- Investigate the substance of the appeal, including any clinical issues involved.
- Have a person or people not involved in the prior adverse decision review this appeal.
- Send you a letter explaining the resolution of the appeal and the basis for the decision within the timeframes defined by your benefit plan or applicable regulations.
- Advise you of your right to seek review of the denial by an independent review organization, and the procedures and form for obtaining that review.
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If your claim was denied because of a benefit that is not covered by your health plan, your appeal will not be reviewed for medical necessity at any level of appeal regardless of your health condition. An appeal for benefits not covered in your health plan will be carefully reviewed to verify that your claim was processed correctly according to the terms of your health plan and or forwarded to your health plan for processing.

Please refer to your Benefit Plan Brochure for all details regarding appeal rights specific to your plan.