HOW TO FILE INTERNAL AND EXTERNAL APPEALS

Please follow the instructions in this document if you disagree with our decision regarding services that require prior approval or pre-service, as described in the Blue Cross and Blue Shield Service Benefit Plan brochure, or a contractual benefit determination made on a post-service claim for a service, supply, or treatment you already received.

These steps may also be found in Sections 3, 7, and 8 of the Blue Cross and Blue Shield Service Benefit Plan brochure. You may designate an authorized representative of your choice, including an attorney, to act on your behalf to appeal claims decisions to us.

For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For all other cases, parties acting as your representative, such as medical providers or family members, must include a copy of your specific written consent with the review request. You may use the authorization form.

To prevent any delay in the review process, please ensure the form is filled out completely, signed and dated, and included with the dispute request. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

BlueCross BlueShield
Federal Employee Program®

INTERNAL APPEALS

Non Urgent Pre-service and Post-service Claims

1. Ask us in writing to reconsider our initial decision. You must:

a. Write to us within six months from the date of our decision; and

b. Send your request to us at the address shown on your explanation of benefits (EOB) form for the local Plan that processed the claim (or, for prescription drug benefits, our Retail Pharmacy Program, Mail Service Pharmacy Program, or the Specialty Drug Pharmacy Program); and

c. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in the brochure; and

d. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and EOB forms.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to respond timely shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the Office of Personnel Management (OPM) review stage.

2. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

a. Precertify your hospital stay or, if applicable, approve your request for prior approval for the service, drug or supply; or

b. Write to you and maintain our denial; or

c. Ask you or your provider for more information.

3. In the case of a post-service claim, we have 30 days from the date we receive your request to:

a. Pay the claim; or

b. Write to you and maintain our denial; or

c. Ask you or your provider for more information.

For both non-urgent pre-service and post-service claims, you or your provider must send the information so that we receive it within 60 days of our request. We will then make our decision with the new information or, if the information was not received, with the information we already have within 30 more calendar days. We will write to you with our decision.

Urgent Care Claims

If you have an urgent care claim (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours after you have followed step one noted above. To request an expedited handling of your reconsideration dispute when this definition is met, you can call the health plan customer service number on the back of your ID card.

We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

If you fail to provide sufficient information for us to make a decision on your expedited request, we will contact you within 24 hours after we receive your reconsideration request. We will allow you up to 48 hours from the receipt of the request to provide the necessary information. If your case warrants expedited handling, we will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the 72-hour time frame, whichever is earlier.

EXTERNAL APPEALS

If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information— if we did not send you a decision within 30 days after we received the additional information.

Immediate Appeals

Our claims and appeals process, described in the Blue Cross and Blue Shield Service Benefit Plan brochure, is required to comply with the rules set forth under the Patient Protection and Affordable Care Act. If you believe that we have violated our claims or appeals procedures, or that our procedures are deficient, you may immediately appeal to OPM. However, if OPM finds that we are in "substantial compliance" with these rules, OPM may reject your immediate appeal. We will be in "substantial compliance" if our failure or violation is 1) minor; 2) non-prejudicial; 3) attributable to good cause or matters beyond our control; 4) in the context of an ongoing good faith exchange of information; and 5) not part of a pattern or practice of non-compliance.

You may send an appeal to OPM at:

United States Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Health Insurance 1
1900 E Street, N.W.
Washington, DC 20415-3610

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Full and Fair Review

You or your authorized representative have the right to ask us to reconsider our claim decisions as described in Section 8 of the Blue Cross and Blue Shield Service Benefit Plan brochure. To help you prepare your reconsideration request, you may arrange with us to provide a copy, free of charge, of all relevant materials, and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact the telephone number on the back of your member identification card, or write to the address on the EOB you received.

We are required to provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim. We will also provide you, free of charge and in a timely manner, with any new rationale for our claim decision. We will provide this information sufficiently in advance of the date by which we are required to provide you with our reconsideration decision to allow you reasonable opportunity to respond prior to that date. We will identify for you the medical or vocational experts whose advice we obtained in connection with the initial decision.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

If we do not substantially comply with these requirements, you may immediately appeal to OPM as explained above.

Avoiding Conflicts of Interest

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a Plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor a subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

If we do not substantially comply with these requirements, you may immediately appeal to OPM as explained above.

Notice Requirements

We must make notices available to you in any language where ten percent or more of the population of your county is literate only in the same non-English language as determined by the Secretary of Health and Human Services. We will include on the English version of all notices, a statement in any applicable non-English language clearly indicating how to access language services, including how to request a copy of the notice in any applicable non-English language. We must also provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language. For assistance please contact the customer service number on the back of your identification card.

Any notice of an adverse benefit determination or reconsideration confirmation that we send must include sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.