Deemed Exhaustion and Immediate Claims Appeal

Under certain circumstances, you may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we have failed to comply with particular aspects of our claims process. You may immediately appeal to OPM if we fail to comply with any of the following requirements or procedures:

Procedures and Time Periods for Claims

You may immediately appeal to OPM if we fail to comply with the procedures and time periods found in Section 8 of our plan brochure in the provisions entitled "Urgent care claims procedures"; "Concurrent care claims procedures"; "Pre-Service claims procedures, prior approval, or required referral"; and "Post-service procedures".

Any time periods for benefit or appeal determinations in the brochure begin at the time a claim for benefits or appeal is filed in accordance with these claims procedures, without regard to whether we receive all information necessary to process a claim. If the necessary information is not included, we may request an extension including a request for the specific information. In such cases, the period for making the determination will be delayed from the date the notification is sent until the date on which you respond with the necessary information.

Form of Benefit Determination or Notification

You may appeal immediately if we fail to provide proper notification. If we decide not to pay your claim, we must provide notice that includes the following:

- The reasons for the adverse benefit determination;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The denial code and its corresponding meaning; and
- A description of our standard used in denying your claim (if applicable).

Full and fair review

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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 health care 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.

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 the 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 fail to comply with any of the procedures described above, then you may be deemed to have exhausted our internal claims procedure, including our reconsideration process. In other words, you may immediately appeal your claim to the Office of Personnel Management without waiting for us to respond to your initial claim or to any request for reconsideration.

Send OPM the following information:

- A letter that states in the first line that you seek immediate appeal outside of the usual appeals process because you believe we have failed to comply with some aspect of our claims procedures;
- A statement about why you believe we violated the procedures described above, based on specific provisions described above or found in the plan brochure;
- Copies of documents that support your assertion that we violated these procedures;
- Copies of documents that support your medical claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

If you believe that your claim qualifies as an urgent care claim, you should also inform OPM that you believe your appeal should be expedited.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group [Plan Health Insurance Group Number], 1900 E Street, NW, 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 a 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.

Note: The deadlines found in Section 8 of the plan brochure still apply to your claim, but these deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.