Information on Claims and Appeals to the Office of Personnel Management

Sections 3 and 7 of your Access+ HMO Plan brochure explains how to file a claim with us. **Section 8** of your Access+ HMO Plan brochure explains your rights to ask us to reconsider our claim decision and how to appeal to the U.S. Office of Personnel Management (OPM) for review of our reconsideration decision for your claim. See below for more information on your rights under the disputed claims process.

Immediate Appeals

Our claims and appeals process, set forth in your Plan brochure, is required to comply with 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 are entitled, upon written request, to an explanation of our basis for asserting that our procedures are substantially compliant. You may contact **Blue Shield of California, Member Services Department, P.O. Box 272550, Chico, CA 95927** to request an explanation.

If OPM rejects your request for immediate review on the basis that we met the standard, you maintain the right to resubmit and pursue your claim and appeal through our claims and appeals process, set forth in your Plan brochure.

You may send an appeal to OPM at:
United States Office of Personnel Management,
Healthcare and Insurance,
Federal Employee Insurance Operations, FEHB 2,
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 each claim.

Note: If anyone other than yourself wishes to file a disputed claim on your behalf with OPM, such as medical providers, that representative must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Time Periods for Claims

Sections 3 and 7 of your Access+ HMO Plan brochure explains how to file a claim with us. We are required to meet the timeframes for claims filed, listed in sections 3 and 7 of your Plan brochure, or you may immediately appeal

to OPM as explained above. 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 information we need to make a decision on your claim is not included with your claim, we may request an extension including a request for the specific information. In such cases, the period for making the determination will be delayed.

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.

Full and fair review

You or your authorized representative have the right to ask us to reconsider our claim decision as described in Section 7 and 8 of the Access+ HMO Plan brochure. To help you prepare your reconsideration request, 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. To make your request, please contact our Customer Service Department by writing to: Blue Shield of California, Member Services Department, P.O. Box 272550, Chico, CA 95927 or calling 800-880-8086.

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.

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

Notice Requirements

We must make notices available to you in any language where 10 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, in the English versions 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.

Any notice of an adverse benefit determination or reconsideration confirming an adverse benefit determination we send must include information sufficient to identify the claim involved (including the date of service, the health care 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).

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

PLEASE REMEMBER THAT WE CANNOT DECIDE PLAN ELIGIBILITY ISSUES. FOR EXAMPLE, WE CANNOT DETERMINE WHETHER YOU OR A DEPENDENT IS COVERED UNDER THIS PLAN. YOU MUST RAISE ELIGIBILITY ISSUES WITH YOUR EMPLOYING OFFICE.