DISPUTED CLAIMS PROCESS – Fact Sheet

All Federal Employee Health Benefit Program members have the right to ask us to reconsider our claim decisions and to request U.S. Office of Personnel Management (OPM) review of our decisions on reconsideration.

Disputed Claims Process Rights and Responsibilities

Our claims and appeals processes, set forth in Sections 3, 7, and 8 of the SAMBA Health Benefit Plan brochure, are required to comply with rules found in OPM's regulations (5 C.F.R. § 890.105) and the 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.

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. An assignment of benefits to the provider is insufficient.

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.

Full and fair review

You or your authorized representative have the right to ask us to reconsider our claim decision as described in Section 8 of the 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 SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 or calling 800-638-6589 or 301-984-1440 (for TTY, use 301-984-4155).

Our reconsideration decision will consider 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.

Reconsideration of urgent pre-service claims

In the case of an appeal of a pre-service (see definition in the Plan brochure) *urgent care claim*, within six months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of the Plan brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

Our response to your reconsideration request for non-urgent claims

Non-urgent pre-service claims

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:

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision; or write to you and maintain our denial.

Non-urgent post-service claims

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

1. Pay the claim or
2. Write to you and maintain our denial or
3. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request We will write to you with our decision within the next 30 days. If we do not receive the information within 60 days, we write to you with our decision within 30 days of the date the information was due.

Your Right to OPM Review

If you do not agree with our decision on reconsideration, 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.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your 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;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.