Disputed Claims

If you have a claim for service and do not agree with our decision, you may request a review from the Health Plan. This is sometimes referred to as an "appeal." The process for filing an appeal is below and also in your Plan Brochure.

PRE-SERVICE CLAIMS

A pre-service claim is for a denial for services that have not been provided yet. If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in the next section.

Contraceptives.
If your claim is in reference to a contraceptive, call 844.633.5325.

Urgent care claims.

- The best, fastest way to request a review of a pre-service urgent care claim is to call Health Plan Customer Service at 844.633.5325.
- You can also request a review by:
  - Fax: 254.298.3663
  - Mail: See "How to request" below.

Non-urgent care claims.
How to request

- Write to us within 6 months from the date of our decision.
- Include:
  - A statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - Copies of documents that support your claims, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
  - (Optional) your email address, if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.
- Send your request
  - By mail to:
    Baylor Scott & White Health Plan
    Attn: Claims
    1206 West Campus Drive
    Temple, TX 76502

    OR
  - By fax to 254.298.3663

When to request

- Your request must be made within 6 months of our initial decision.
- 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.

OPM Review

After we reconsider your pre-service claim, if you do not agree with our decision, you may ask OPM to review it. See the OPM Review section (page 4) for more information.

POST-SERVICE CLAIMS

When you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided).

FYI

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, whether or not that information was available or considered in the initial determination.

The reconsideration will not be made by the same person who made the original decision, or their subordinate.

Requesting a reconsideration

- Write to us within 6 months from the date of our decision.
- Include:
  - a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
  - copies of documents that support your claims, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
  - (Optional) your email address, if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.
- Send your request
  - By mail to:
    Baylor Scott & White Health Plan
    Attn: Claims
    1206 West Campus Drive
    Temple, TX 76502
    OR
  - By fax to 254.298.3663

Preparing your appeal

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.

To make your request, please contact our Customer Service Department by:

- writing to:

  Baylor Scott & White Health Plan
  Attn: Customer Service Department
  1206 West Campus Drive
  Temple, TX 76502

- or calling 844.633.5325.

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.
- 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 timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described below.

Timing for post-service claims

- Your request must be made within 6 months of our initial decision.
- We have 30 days from the date we receive your request to:
  - Pay the claim or
  - Write to you and maintain our denial or
  - 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.

OPM REVIEW

If you do not agree with our decision, you may ask OPM to review it.

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.

When (timing)

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.

Note: The deadlines above may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

What (required information)

- A statement about why you believe our decision was wrong, based on specific benefit provisions in your Plan Brochure;
- Copies of documents that support your claims, 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;
- 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.

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

Where (to mail your request)

United States Office of Personnel Management, Healthcare, and Insurance, Federal Employees Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Next (OPM's process)

OPM will:

- Review your disputed claim request.
- Use the information it collects from you and us to decide whether our decision is correct.
- Send you a final decision or notify you of the status of OPM's review within 60 days.

There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit.