

CLAIMS AND APPEALS

NOTICE OF CLAIM DECISION

The Carrier will give you notice of the decision on a claim. The notice will be in writing, and will tell you about the specific reasons for the action. It will refer to the specific provisions of the Plan on which the denial is based and explain whether any additional information is required from you. In the notice, the Carrier will identify the address to use for your appeal. The Carrier will decide your claim within the deadline for the type of claim involved (i.e., urgent claim, pre-service claim, post-service claim or concurrent care claim). These types of claims and the rules applicable to each are described below. If you have submitted a claim for Medical or Prescription Drug benefits and it has been denied due to the Plan's determination regarding your enrollment or eligibility status, it will also be subject to these rules and deadlines. A detailed description of the claims and appeals procedures is in the plan document. If these descriptions inadvertently disagree with the plan documents, the plan documents will prevail.

Urgent Care Claims

Special rules apply to claims requesting urgent medical care. These rules require notification to you about your claim status within 72 hours after receipt of the request for review. Specifically, an urgent care claim is any claim for medical care or treatment, which, if determined within the time periods for making determinations of pre-service claims:

1. Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
2. Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Provider with knowledge of your condition.

Concurrent Claims

A concurrent claim is a claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits. In the case of a concurrent claim, as defined by applicable regulations, the Carrier will notify you of the benefit determination as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated.

Pre-service Claims

A pre-service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before you obtain medical care. In the case of a pre-service claim, as defined by applicable regulations, the Carrier will notify you of the benefit determination within a reasonable period of time, appropriate to the medical circumstances, but not later than 15 days (which may be extended by an additional 15 days if additional information is needed) after receipt by the Carrier of your request for a benefit determination. If an extension is necessary for additional information, you will be given at least 45 days to submit the information.

Post-service Claims

Post-service claims are any claims for health care benefits that are not pre-service claims. In the case of a post-service claim, as defined by applicable regulations, the Carrier will notify you of the benefit determination within a reasonable period of time, but not later than 60 days (which may be extended by an additional 15 days if additional information is needed) after receipt by the Carrier of your request for a benefit determination. If an extension is necessary for additional information, you will be given at least 45 days to submit the information.