How to File a Claim

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription.

The procedure is simple. Just take the following steps:

- ***Know Your Benefits.*** Review this information to see if the services you received are eligible under your medical program.

- ***Get an Itemized Bill.*** Itemized bills must include:

  - The name and address of the service or pharmacy provider;
  - The patient's full name;
  - The date of service or supply or purchase;
  - A description of the service or medication/supply;
  - The amount charged;
  - For a medical service, the diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage;
  - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

  Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. Claim forms are available from your employee benefits department, or call the member/customer service telephone number on the back of your ID card.

- **Attach Itemized Bills to the Claim Form and Mail.** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services or medications for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

If you file the claim yourself, your claim must be submitted within 90 days of the date of service, but in no event will it be accepted later than one year from the 90-day timeframe.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by the insurance company;
- the copayment; deductible and coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with the insurance company, you will receive an EOB only when you are required to pay amounts other than your required copayment.

Using the Mail Service Pharmacy Benefit

To order your prescription through the mail service pharmacy, visit the insurance company Web site or call member/customer service using the telephone number on the back of your ID card to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and any applicable copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form. Your order will be processed promptly and your medication will be sent to you via U.S. mail or UPS. Included with your order will be instructions for ordering refills. Refills can be ordered by phone, mail or online.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the member/customer service department using the telephone number on your ID card.

Filing Benefit Claims

- ***Authorized Representatives***

  You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. The insurance company reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claim***

  For a description of how to file a request for precertification or other pre-service claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of your benefit booklet.

- **Requests for Reimbursement and Other Post-Service Claims**

  When a hospital, physician or other provider submits its own reimbursement claim, the amount paid to that provider will be determined in accordance with the provider's agreement with the insurance company or the local licensee of the insurer serving your area. The insurance company will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with the insurance company. For instructions on how to file such claims, you should contact the member/customer service department using the telephone number on your ID card.

Determinations on Benefit Claims

- ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***
  For a description of the time frames in which requests for precertification or other pre-service claims will be determined by The insurance company and the notice you will receive concerning its decision, whether adverse or not, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Healthcare Management section of your benefit booklet.

- **Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims**
  The insurance company will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by The insurance company for an additional 15 days, provided that The insurance company determines that the additional time is necessary due to matters

outside its control, and notifies you of the extension prior to the expiration of the initial 30-day postservice claim determination period. If an extension of time is necessary because you failed to submit information necessary for the insurance company to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your postservice claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Appeal Procedure

Internal Appeal Process

The insurance company maintains an internal appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify the insurance company in writing of the designation. For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. The insurance company reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the insurance company shall, in the case of an urgent care claim, permit a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

At any time during the appeal process, you may contact the member/customer service department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

If you receive notification that your coverage has been rescinded or that a claim has been denied by the insurance company, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

Upon request to the insurance company, you may review all documents, records and other information relevant to your appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements,

comments and/or remarks, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim or matter which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the insurance company. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

Each appeal will be promptly investigated and the insurance company will provide written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim or a decision by the insurance company to rescind coverage, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

If the insurance company fails to provide notice of its decision within the above-stated time frames or otherwise fails to strictly adhere to these appeal procedures, you may be permitted to request an external review and/or pursue any applicable legal action.

In the event the insurance company renders an adverse decision on your internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to request an external review and/or pursue any applicable legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review Process

You shall have four months from the receipt of the notice of the insurance company's decision to appeal the denial resulting from the internal appeal process by requesting an external review of the decision. To be eligible for external review, the insurance company's decision to be reviewed must involve:

- a claim that was denied involving medical judgment, including application of the insurance company's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational, or
- a determination made by the insurance company to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or your health care provider, with your written consent in the format required by or acceptable to the insurance company. The request for external review should include any reasons, material justification and all reasonable necessary supporting information as part of the external review filing.

Preliminary Review and Notification

Within five business days from receipt of the request for external review, the insurance company will complete a preliminary review of the external review request to determine:

- in the case of a denied claim, whether you are or were covered under this program at the time the covered service which is the subject of the denied claim was or would have been received;
- whether you have exhausted the insurance company's internal appeal process, unless otherwise not required to exhaust that process; and
- whether you have provided all of the information and any applicable forms required by the insurance company to process the external review request.

Within one business day following completion of its preliminary review of the request, the insurance company shall notify you, or the health care provider filing the external review request on your behalf, of its determination.

In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request in which case you, or the health care provider filing the external review request on your behalf, must correct and/or complete the external review request no later than the end of the four month period in which you were required to initiate an external review of the insurance company's decision, or alternatively, 48 hours following receipt of the insurance company's notice of its preliminary review, whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by the insurance company will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Final Review and Notification

Requests that are complete and eligible for external review will be assigned to an independent review organization (IRO) to conduct the external review. The assigned IRO will notify you, or the health care provider filing the external review on your behalf, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which you or the health care provider may have in support of the request must be submitted, in writing, within 10 business days following receipt of the notice. Any additional information timely submitted by you or the health care provider and received by the assigned IRO will be forwarded to the insurance company. Upon receipt of the information, the insurance company shall be permitted an opportunity to reconsider its prior decision regarding the claim that was denied or the matter which is the subject of the external review request.

The assigned IRO will review all of the information and documents that it timely received and make a decision on the external review request. The decision shall be made without regard or deference to the decision that was made in The insurance company's internal appeal process. The assigned IRO shall provide written notice of its final external review decision to the insurance company and you, or the health care provider filing the external review request on your behalf, within 45 days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO, a statement that judicial review may be available to you and current contact information for the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review (applies to urgent care claims only)

If the insurance company's initial decision or the denial resulting from the insurance company's internal appeal process involves an urgent care claim, you or the health care provider on behalf of you may request an expedited external review of the insurance company's decision. Requests for expedited external review are subject to review by the insurance company to determine whether they are timely, complete and eligible for external review. When the request involves a denied urgent care claim, the insurance company must complete its preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the insurance company must then transmit all necessary documents and information that was considered in denying the urgent care claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within 48 hours following initial notice of its final external review decision, written confirmation of that decision to the insurance company and you, or the health care provider filing the expedited external review request on your behalf.

Member Assistance Services

You may obtain assistance with the insurance company's internal appeal and external review procedures as described herein by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.