Group Health Options, Inc. Federal Plans
Deemed Exhaustion and Immediate Claims Appeal

Information on claims appeals to the Office of Personnel Management

Section 8 of your Plan brochure explains your rights to ask us to reconsider our claim decision and how to seek review by the U.S. Office of Personnel Management (OPM) of our reconsideration decision for your claim. See below for more information on your rights under the disputed claims process.

Immediate appeals

You may immediately appeal to OPM if we fail to respond in any way to your request for reconsideration 30 days after the receipt of a timely-filed request from you. 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 from the date the notification is sent until the date on which you respond with the necessary information.

You may send an appeal to OPM at:

United States Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Health Insurance 2
1900 E. Street N.W.
Washington, DC 20415-3620

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

Procedures and time periods for claims

Section 7 of the Plan brochure explains how to file a claim with us and explains four different claim categories:

- Urgent care claims;
- Concurrent care claims;
- Pre-service claims, prior approval, or required referral; and
- Post-service claims.

We will notify you of our decision on an urgent care claim or reconsideration of an urgent care claim decision as soon as possible and usually within 24 hours as explained in Sections 7 and 8 of your Plan brochure. However, we are allotted 72 hours to make a decision on urgent care claims if necessary.

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.

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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 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 write to:

Group Health Options, Inc. Appeals Department
PO Box 34593
Seattle, WA 98124-1593
Or fax your request to:
206-901-7340

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 also will 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.

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.

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.

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.