How to File an Appeal

The Disputed Claims Process

This document covers the basics of the appeals process, from filing an appeal to understanding your legal rights. This information is also available in Sections 3, 7, and 8 of your Select Health FEHB brochure.

To avoid delays in the review process, please ensure your appeals form is filled out completely before submission.

Questions about the appeals process?
Contact Select Health Member Services at **844-345-3342**.

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Internal Appeals

NON-URGENT CARE CLAIMS

Pre-service claims procedures

You may ask us, in writing, to reconsider a decision **within 6 months** of receiving our initial decision. Follow Step 1 of the disputed claims process in this guide. For further details, see Section 8 of the Select Health FEHB brochure.

We have **30 days** from the date we receive your written request to:

1. Preauthorize your hospital stay, arrange for your healthcare provider to give you requested care, or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
    c. 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**.
    d. 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 and notify you of our decision in writing.

Post-service claims procedures

We will notify you of our decision **within 30 days** of receiving your post-service claim. If matters beyond our control require an extension of time, we may take up to an **additional 15 days** for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received the necessary information from you, our notice will describe the specific information required and we will allow you **up to 60 days** from the receipt of the notice to provide the information.

URGENT CARE CLAIMS

Pre-service claims procedures

You may ask us in writing to reconsider our decision **within 6 months** of our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of the Select Health FEHB brochure.

Unless we request additional information, we will notify you of our decision **within 72 hours** of receiving your reconsideration request for a claim that qualifies as an urgent care claim (see your Select Health FEHB brochure for information about what claims qualify). 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

If you disagree with our decision after we reconsider your pre-service or post-service claim, you may ask OPM to review it by following the disputed claims process in this brochure. For more details, see Section 8 of the Select Health FEHB brochure.

If we do not follow the required claims processes, you may appeal directly to the Office of Personnel Management (OPM). For questions or more information about appeals to OPM, including requirements not listed in Sections 3, 7, and 8 of the Select Health FEHB brochure, or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, contact your Plan's customer service representative at the number found on your enrollment card, Plan brochure, or Plan website.

APPEAL PREPARATION

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 request appeal preparation assistance, contact the Select Health Appeals department:

Email: **appeals@selecthealth.org**
Phone: **844-208-9012**

APPEAL 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 a healthcare professional who has the appropriate training and experience in the field of medicine involved in the medical judgment, and who was not involved in making the initial decision.

The initial decision will not impact our reconsideration. The review will not be conducted by the same person or team who made the initial decision. We do not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based on the likelihood that an individual (such as a claims adjudicator or medical expert) will support the denial of benefits.

DISPUTED CLAIMS PROCESS

STEP 1: Ask us in writing to reconsider our initial decision.

You must:

a. Write to us **within 6 months** of the date of our decision.

b. Send your request to:

   Mail: Select Health, Appeals Department
   P.O. Box 30192
   Salt Lake City, UT 84130-0192

   Email: **appeals@selecthealth.org**

   Online: **selecthealth.org/resources/forms**; and

c. Include a statement about why you believe our initial decision was wrong, based on the specific benefit provisions described in the Select Health FEHB brochure.

d. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e. Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to more quickly notify you of our decision.

Note: For additional details, see Section 8 of the Select Health FEHB brochure.

STEP 2: In the case of a post-service claim, we have 30 days from the date we receive your request to:

a. Pay the claim, or

b. Write to you and maintain our denial, or

c. Ask you or your provider for more information

We must receive the requested information from you or your provider **within 60 days** of our request. We will then decide **within 30 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 notify you of our decision in writing.

STEP 3: If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days of the date on 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 3
1900 E Street, NW, Washington, DC 20415-3630

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in the Select Health FEHB 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 the letters you sent to us about the claim;
- Copies of all the letters we sent 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. If you provide your email address, you may receive your decision more quickly.

Note: For additional details, see Section 8 of the Select Health FEHB brochure.

STEP 4: OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of their review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by **December 31** of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the records OPM used when they decided to uphold or overturn our decision. You may only recover the benefits amount in dispute.

IMPORTANT CONSIDERATIONS

If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was for urgent care, then call us toll-free at **844-208-9012**. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at **202-606-0737** between 8 a.m. and 5 p.m. (EST).

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

We do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

FAIR TREATMENT NOTICE

SelectHealth, Inc. obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting SelectHealth, Inc.: **844-345-3342**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

This Plan's SBCs and brochure are available on the internet at: **selecthealth.org/fehb**. A paper copy is also available, free of charge, by calling **844-345-3342** (a toll-free number).

This is a brief description of the features of SelectHealth, Inc. Before making a final decision, please read the Plan's Federal brochure (RI 73-865). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure.

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