Postal Service Health Benefits Program Appeal and Disputed Claims Processes

Follow the steps below if you disagree with our decision on your post service claim or pre-service precertification/prior approval denial request for services, drugs, or supplies.

Please refer to Section 3 of the **Plan brochure** for pre-service appeals and Section 8 for disputed claims.

If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our pre-service or post-service decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8(a) of the Plan brochure.

How to file an appeal or disputed claim

Step 1

Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at:

- MHBP Postal Service Health Benefits Program
  PO Box 981106
  El Paso, TX 79998-1106
- Fax: 859-455-8650
- Through a secure message via the **Aetna member website**; and

c) Include a statement or complete this **form** about why you believe our initial decision was wrong, based on specific benefit provisions in the Plan brochure; and

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

e) Include your email address (optional), 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.

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 us at MHBP Postal Service Health Benefits Program, PO Box 981106, El Paso, TX 79998-1106 or by calling us at the number found on the back of your ID card, plan brochure or plan website.

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 a claim for urgent care, then call us at the number found on the back of your ID card, plan brochure or plan website. We will expedite our review (if we have not yet responded to your claim); or we will inform the Office of Personnel Management (OPM) so they can quickly review your claim on appeal.

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.

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.

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.

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. We will 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 Office of Personnel Management (OPM) review stage described in Step 4 below.

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 it, 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.

Step 3

If you do not agree with our decision, you may ask the Office of Personnel Management (OPM) to review it.

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.

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

Write to OPM at:

United States Office of Personnel Management
Healthcare and Insurance
Postal Service Insurance Operations (PSIO)
1900 E Street NW, Room 3443
Washington, DC 20415

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in the Plan 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 letters you sent to us about the claim;
- Copies of all letters we sent to 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. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

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 complete the **Authorized Representative form**. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Step 4

The Office of Personnel Management (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 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 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 cannot 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 record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

How to file an appeal related to our claim procedures or appeals procedures

Our claims and appeals process, set forth in the Plan brochure, is required to comply with rules set forth under the Patient Protection and Affordable Care Act. If you believe that we have violated our claims or appeals procedures, or that our procedures are deficient, you may immediately appeal to OPM. If OPM rejects your request for immediate review on the

basis that we met the standard, you maintain the right to resubmit and pursue your claim and appeal through our claims and appeals process, set forth in the Plan brochure.

For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of the Plan brochure, please call your plan's customer service representative at the phone number found on the back of your ID card, plan brochure, or plan website.

You are entitled, upon written request, to an explanation of our basis for asserting that our procedures are substantially compliant. You may contact the Plan to request an explanation:

MHBP
PO Box 981106
El Paso, TX 79998

Time periods for claims

Sections 3 and 7 of the **Plan brochure** explain how to file a claim with us. We are required to meet the timeframes for claims filed, listed in these sections or you may immediately appeal to OPM as explained above. 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.

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.

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 reconsideration request, 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 MHBP, PO Box 981106, El Paso, TX 79998 or by calling us at the number found on the back of your ID card, plan brochure or plan website.

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 will also 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.

If we do not substantially comply with these requirements, you may be able to immediately appeal to OPM as explained above.

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.

If we do not substantially comply with these requirements, you may be able to immediately appeal to OPM as explained above.