Appeal for internal review

If you do not agree with the decision made by the plan, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB) or adverse decision.

Submitting an appeal for internal review

You or your authorized representative* must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.

The appeal should be mailed or faxed to Premera:
Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202
FAX: 425-918-5592

An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage, or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.

If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

*You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (this may be your attorney or your provider), you must submit a completed and signed Microsoft Member Appeal Form, which includes an appeal authorization section.

In the case of an urgent care appeal, you may submit your appeal request orally or in writing, and all necessary information may be transmitted between you and the plan by telephone or fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as the internal review process by Premera Blue Cross. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is binding upon the Plan.

To file an urgent care appeal request, you may fax a request to **425-918-5592**

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

? The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.

? An **urgent care claim or appeal** is one in which the application of the standard time periods for making determinations could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the event any new or additional information (evidence) is considered, relied on, or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

Other than urgent care appeals, described above, in most cases Premera will send a decision on your appeal no later than 60 calendar days after receipt of your appeal request. However, if the appeal relates to an item for which the Plan requires you to obtain approval before it is furnished to you, then it will be considered a pre-service appeal, and Premera will send a decision no later than 30 calendar days after the receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice containing the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under the Employee Retirement Income Security Act (ERISA) Section 502(a)
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in denying the claim. A copy of the information will be provided free upon request
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination. A copy of the explanation will be provided free upon request

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera customer service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial (1) has a retroactive effect and is considered a recession of coverage under the law, or (2) is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is binding upon the plan.

An independent review organization (IRO) is an independent organization of medical experts who are qualified to review medical and other relevant information.

If you fail to submit the written request within this timeframe, you will permanently lose your right to an external review.

Submitting an appeal for external review

To initiate the external review, you must send a written request to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.

Mail or fax the written request to:
Premera Blue Cross
Attn: Microsoft Member Appeals – IRO Mail Stop 123
PO Box 91102
Seattle, WA 98111-9202
FAX: 425-918-5592

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt of your request.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information and the IRO review begins.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message, or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred. In addition, you must raise all issues and grounds for appealing a decision on a claim for benefits at every stage of the appeals process, or else such issues and grounds will be deemed permanently waived and barred.

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera customer service for assistance at **800-676-1411 (TTY: 711)**. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at **866-444-EBSA (3272)**.

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

An Independent Licensee of the Blue Cross Blue Shield Association
037397 (07-05-2024)

PREMERA | BLUE CROSS