DISPUTED CLAIMS PROCESS
For more information about your rights to ask us to reconsider our claim decision, see your PSHB Plan Brochure.

For Post- and Pre-service Medical and Pharmacy Claims

How to file a disputed claim
Ask us in writing and write to us with six months from the date of our decision.

Your **written request** must be mailed or faxed to the following:

Hawaii Medical Service Association
Attn: Member Advocacy & Appeals
P.O. Box 1958
Honolulu, HI 96805-1958
Fax No.: (808) 952-7546 or (808) 948-8206

Online form: hmsa.com/help-center/forms/member-appeal/

You can also email your appeal to appeals@hmsa.com, however, please note that unencrypted email could be intercepted. If you do not want to take this risk, please fax or mail your appeal.

If you have any questions regarding disputing a claim, please call (808) 948-5090 or 1 (800) 462-2085.

Your request must include all of the following information:

- A statement about why you believe our initial decision was wrong, based on specific benefit provisions in your PSHB plan brochure; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms.
- Include your email address if you would like to receive our decision via email. Please note that by giving HMSA your email address, we may be able to provide our decision more quickly.

To further assist HMSA with processing your appeal, please include the following information:

- The date of your request.
- Your name and telephone number.
- Address and birthday of member who received services.
- The date of our denial of coverage for the requested service or supply (may include copy of denial letter).
- The subscriber number from your HMSA membership card.
- The provider's name.

Response time
For a post-service claim, HMSA has 30 days from the date we receive your request to:

- Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
- Write to you and maintain our denial; or
- Ask you or your medical provider for more information.

If we need 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 days of the date the information was received.

If we do not receive the information within 60 days, we will base our decision on the information we already have and will respond within 30 days of the date the information was due.

Expedited appeals
You may request an expedited appeal if application of the above (30 days) time period may:

- Seriously jeopardize your life or health,
- Cause permanent loss of bodily functions, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

We will respond to your expedited appeal request as soon as possible, taking into account your medical condition, but not later than **72 hours**, after all information sufficient to make a determination is provided to us. You may request for an expedited appeal by calling (808) 948-5090 or 1 (800) 462-2085.

Who can request an appeal:
Either you, your authorized representative, a court-appointed guardian, or an agent under a health care proxy may request an appeal. An authorized representative includes any person you authorize to act on your behalf provided you follow our procedures, which include filing a form with us.

To obtain a form to authorize a person to act on your behalf, call (808) 948-5090 or 1 (800) 462-2085. The form is also available on hmsa.com.

Information available from us:
We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generate 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

• Any other information relating to the claim for benefits including written comments, documents, and records you would like us to review. You should keep a copy of your request for your records. It will not be returned to you.	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. You may also request, and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

If you disagree with our appeal decision, send your written request to OPM at:

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

Your written request to OPM must be within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to HMSA. 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.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in your 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 HMSA about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- 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.

Immediate appeals:

Our claims and appeals process, set forth in your 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. However, if OPM finds that we are in "substantial compliance" with these rules, OPM may reject your immediate appeal. We will be in "substantial compliance" if our failure or violation is 1) minor; 2) non-prejudicial; 3) attributable to matters beyond our control or a good cause; 4) in the context of an ongoing good faith exchange of information; and 5) not part of a pattern or practice of non-compliance.

You are entitled, upon written request, to an explanation of our basis for asserting that our procedures are substantially compliant. You may contact Member Advocacy & Appeals at (808) 948-5090 or 1(800) 462-2085 to request an explanation.

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 your Plan brochure.

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

You may send an appeal to OPM at:

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

You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. 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.

OPM will review your disputed claim request and will use the information it collects from you and HMSA to decide whether HMSA's decision is correct. OPM will send you a final decision 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 sue, you must file the suit against OPM in federal court by Dec. 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 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 sue until you have completed the disputed claims process. Further, federal laws govern 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 HMSA's decision. You may recover only the amount of benefits in dispute.