

**BLUE CROSS BLUE SHIELD OF DELAWARE-  
GRANDFATHERED PLAN APPEAL PROCESS**

**For State of Delaware First State Basic Plan,  
Comprehensive Preferred Provider Organization (Comp-PPO) Plan,  
Blue Care HMO Plan, or  
Blue Cross Select Point of Service (POS) Plan  
(Port of Wilmington Employees Only)**

OFFICE OF MANAGEMENT & BUDGET  
STATEWIDE BENEFITS OFFICE

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**INITIAL SERVICE**

Employee receives service and a claim is filed by the employee (or by provider on employee's behalf) with Blue Cross.

**IF DENIED and member has potential liability to provider,**

**LEVEL I APPEAL – ADMINISTERED BY BLUE CROSS**

Employee may file an appeal with Blue Cross within 180 days from receipt of the notice of denial to request a review of the initial claim decision,

- ❖ Blue Cross will review the appeal and provide a written decision to the employee
  - a. Within 30 days for Pre-Service requests. Expedited appeals may be requested for a denial relating to urgent care; Blue Cross will notify the employee and provider within 72 hours or,
  - b. Within 45 to 60 days for Post-Service requests.

**IF DENIAL IS UPHELD,**

**LEVEL II APPEAL – ADMINISTERED BY BLUE CROSS**

Employee may file a Level II appeal for an independent review of a decision involving medical judgment including care classified as cosmetic or experimental. Medical judgment denials are when a qualified medical staff makes an adverse determination that denies, reduces or terminates health care benefits based on medical necessity including cosmetic or experimental care.

### **Medical Judgment -Level II Appeals:**

Employee may file a Level II appeal for an independent review of a decision involving medical judgment including cosmetic or experimental care to Blue Cross, in writing, within 60 days from receipt of the notice of denial of the Level I appeal. Please include the Blue Cross appeal decision letter in Level I and all relevant information. Blue Cross will review the appeal and provide a written decision to the employee within 30-45 days. An expedited review is available if the treating physician certifies that a delay in receiving the service would jeopardize the health of the employee. Expedited reviews are decided within 3 to 5 calendar days.

### **Non-Medical Judgment Appeals:**

Non-Medical Appeals are defined as administrative decisions regarding fee schedules, contractual exclusions and benefit determinations that do not require a medical staff review. For all Non-Medical Appeals, please continue to Level III which is administered by the State of Delaware-Statewide Benefits Office.

### **LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE – STATEWIDE BENEFITS OFFICE**

Employee may file an appeal of the denial in writing to the Statewide Benefits Office within 20 days of the postmark date of the notice of denial of the Level II appeal.

Appeals Administrator  
RE: APPEAL  
Statewide Benefits Office  
500 W. Loockerman Street, Suite 320  
Dover, DE 19904

- ❖ Appeal must contain how the employee may be contacted (mailing address, telephone number, etc) a written summary of events, applicable Explanation of Benefits (EOBs), a copy of the employee's Identification Card or the plan name and employee's identification number (as on Identification Card) and any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information form to provide authorization to the Statewide Benefits Office to obtain applicable information from Blue Cross. This form is available at [http://ben.omb.delaware.gov/medical/documents/auth\\_to\\_release\\_form.pdf](http://ben.omb.delaware.gov/medical/documents/auth_to_release_form.pdf) Employees submitting an appeal without signed form will be requested, in writing, to submit form. Statewide Benefits Office will not begin to review the appeal until State of Delaware's Authorization for Release of Protected Health Information form is received.
- ❖ The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written

notice of the decision to the employee and Blue Cross within 30 days of receiving the appeal.

**IF DENIAL IS UPHELD,**

**LEVEL IV APPEAL – ADMINISTERED BY THE STATE OF DELAWARE –  
STATE EMPLOYEE BENEFITS COMMITTEE**

Employee may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial from the Statewide Benefits Office.

Chair, State Employee Benefits Committee (SEBC)  
RE: APPEAL  
Office of Management and Budget  
Haslet Armory, Third Floor  
122 William Penn Street, Suite 301  
Dover, DE 19901

- ❖ The SEBC receives the appeal and:
  - a) Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing. The SEBC accepts or modifies the report, and notice of the decision is postmarked to the employee within 60 days; **OR**
  - b) Hears the appeal, and notice of the decision is postmarked to the employee within 60 days of the hearing.

**IF DENIAL IS UPHELD,**

**LEVEL V APPEAL – DELAWARE SUPERIOR COURT**

The employee may appeal the decision to the Delaware Superior Court within 30 days of the postmark date of the notice of denial from the SEBC.