

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

**For State of Delaware's Consumer-Directed Health Gold Plan  
(CDH Gold Plan)**

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 employee 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 THE STATE OF DELAWARE'S  
DEPARTMENT OF INSURANCE.**

Employee may file a Level II appeal for an external review of a decision involving medical judgment including care classified as cosmetic or experimental. Medical judgment denials are when 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 external review of a decision involving medical judgment including cosmetic or experimental care to Blue Cross, in writing, within 60 days from receipt of the Blue Cross appeal notice. Please include the Blue

Cross appeal decision letter and all relevant information. Blue Cross will initiate an independent review with the State of Delaware's Department of Insurance.

The Department of Insurance will assign your appeal to an Independent Utilization Review Organization (IURO) who will provide the employee with a written decision within 45 days of assignment to the IURO. If the treating physician certifies that a delay in receiving the service would jeopardize the health of the employee, the IURO will provide the employee with a written decision within 72 hours.

**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, the employee may initiate an appeal by filing a Petition for Arbitration with the State of Delaware's Department of Insurance Consumer Services Division within 60 days from receipt of the notice of denial of the Level I appeal. The employee may call the Department of Insurance at 302-739-4251 or 1-800-282-8611 or visit the Department of Insurance at The Rodney Building, 841 Silver Lake Boulevard, Dover, DE 19904. Office hours of the Department of Insurance are 8:30 AM to 4:00 PM Monday through Friday.

The Department of Insurance will provide the employee with a written decision within 45 days.

**IF DENIAL IS UPHELD,**

**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.