Claims and Appeals Process for the Pacific Gas and Electric Company Self-Funded Medical Plans Administered by Blue Cross of California

Filing a Claim for Benefits

Blue Cross of California on behalf of BC Life & Health Insurance Company is the claims administrator for the self-funded medical plans sponsored by PG&E. As the claims administrator, Blue Cross of California contracts with a network of providers and processes claims. Blue Cross of California pays the network providers directly for your covered Health Services. You are responsible for paying copayments and/or deductibles to the network provider at the time of service or when you receive a bill from the provider. If a network provider bills you for any Covered Health Service, contact Blue Cross of California at 1-800-964-0530.

When you receive Covered Health Services from a non-network provider, you are responsible for paying the provider up front and filing a claim with Blue Cross of California, even if your services were due to an emergency or because your network provider referred you to a non-network provider. You must file the claim in a format that contains all of the information required, as described below. Claim forms may be obtained by calling Blue Cross of California at 1-800-964-0530 or by accessing the website at www.bluecrossca.com/clients/pge.

You must file a claim for payment of benefits within two years of the date of service. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient hospital stay, the date of service is the date on which your inpatient stay ends. If you don't file a claim and provide all required information to Blue Cross of California within two years of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits from Blue Cross of California, you must provide them with all of the following information.

a) The member's name and address.
b) The patient's name, age, and relationship to the member.
c) The member {and Group} number stated on your ID card.
d) An itemized bill from your provider that includes the following:
   - Patient diagnosis
   - Date(s) of service
   - Procedure code(s) and descriptions of services(s) rendered
   - Charge for each service tendered
   - Provider name, address, and Tax Identification Number (TIN)
e) The date of the injury or sickness began

f) A statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Send your claim to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

Payment of Benefits for Non-Network Benefits

Blue Cross of California will make a benefit determination on non-network services as set fourth below. Benefits will be paid directly to you unless either of the following is true:

- The provider notifies the Claims administrator that your signature is on file, assigning benefits directly to that provider; or
- You make a written request for the non-network provider to be paid directly at the time you submit your claim.

Blue Cross of California will not reimburse third parties who have purchased or been assigned benefits to physicians or other providers.

Benefit Determinations (Before an Appeal is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or current claim. Depending on the type of the claim, Blue Cross of California must process your claim within different time-frames. The processing time-frames for each type of claim are explained below.

Post-Service Claims

- Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, Blue Cross of California will send you a written in the form of an Explanation of Benefits within 30 days of receipt of the claim, provided that all required information was included with the claim. Blue Cross of California will notify you within this 30-day period if additional information is needed to process your claim, and may request a one-time extension of no longer than 15 days and pend your claim until all, required information is received.
- If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Blue Cross of California. If all of the required information is received within 45-day time-frame and the claim is then denied, Blue Cross of California will notify you of the denial within 15 days of the receipt of the additional information. If you do not provide the needed information within the 45-day period, your claim will be denied.

- If your claim is denied, the denial notice- typically an Explanation of Benefits statement- will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Pre-Service Claims

Pre-Service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent may be requested by the network provider by calling (800) 274-7767 or may be submitted in writing and sent to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

If your claim is a pre-service claim and was submitted properly will all required information, Blue Cross of California will send you and your network provider written notice of its claim decision in 15 days of receipt of the claim. If you file a pre-service claim improperly, Blue Cross of California will notify you and the network provider that the claim was improperly filed within 5 days of receiving the pre-service claim and give you information on how to correct it. If additional information is needed to process the pre-service claim, Blue Cross of California will notify you within 15 days of the receipt of the claim that additional information is needed, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notification of an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Blue Cross of California. If all of the required information is received within the 45-day time-frame, Blue Cross of California will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

If your claim is denied, the denial notice will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims (1) that require notification or approval prior to receiving medical care, and (2) where a delay in treatment could jeopardize your life, health, or the ability to regain maximum function or, in the opinion of the physician with knowledge of your medical condition, could cause severe pain. In these situations, you or your network provider may submit your request in writing to the address listed above or call Blue Cross of California at 1-800-274-7767. After Blue Cross of California receives the request, you will receive a response as follows:

- You and your network provider will receive notice of the benefit determination in writing or by telephone within 72-hours of Blue Cross of California's receipt of all

necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written confirmation to follow within three days.

- If you file an urgent care claim improperly, Blue Cross of California will notify you or your network provider that the claim was improperly filed within 24 hours of receiving the urgent claim and give you information on how to correct it. If additional information is needed to process the claim, Blue Cross of California will notify you or your network provider of the information needed within 24 hours of receiving the claim. You will have 48 hours to provide the requested information.

You are or network provider will be notified of Blue Cross of California's determination no later than 48 hours after:

- Blue Cross of California receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

If your claim is denied, the notice of the denial will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider request to extend the treatment as an urgent care claim as defined above, Blue Cross of California will make a determination on your request for the extended treatment within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time-frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time-frames, whichever applies.

Concurrent claims that are considered urgent may be submitted in writing or by calling Blue Cross of California at 1-800-274-7767. Non-urgent claims may also be submitted in writing and sent to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

<u>To Resolve a Problem</u>

Blue Cross of California has established a complaint resolution and grievance process to resolve members' problems or complaints. If you or a covered dependent has a question, problem, or complaint, you should call 1-800-964-0530 or write to the address below:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Customer Service again and state that you would like to file an appeal. You may also send your written appeal to the address above.

If you are appealing an urgent care claim denial, please refer to the ***Urgent Claim Appeals that Require Immediate Action*** section on page 6 and contact Member Services at 1-800-964-0530 immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during posted business hours, Monday through Friday.

<u>Appeals</u>

<u>*How to Appeal a Claim Decision- Non-Urgent*</u>

If you still disagree with a claim determination after following the above steps, you can contact Blue Cross of California in writing to formally appeal the claim. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from your ID card.
- The date(s) of medical service(s)
- The providers name
- The reason you believe the claim should be paid
- Any document or other written information to support your request for claim payment

Send your appeal to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060

Your first request to appeal the claim must be submitted to Blue Cross of California **within 180 days** of your receipt of the claim denial.

Appeals Process

Two levels of appeals are provided for each claim. In each appeal step, a qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be conducted by a health care professional that has appropriate expertise and was not involved in any prior determination. Blue Cross of California may consult with, or seek the participation of medical experts as part of the appeal resolution process. If applicable, you must consent to this referral and the sharing of pertinent medical claim information to continue the appeal process. You may request, at no cost, to have access to and copies of all documents, records, and other information relevant to your claim for benefits.

To initiate a second appeal, you must follow the same steps as outlined above in ***How to Appeal a Claim Decision – Non-Urgent*** or as described under ***Urgent Claim Appeals that Require Immediate Action*** on Page 6. Your second-level appeal must be submitted to Blue Cross of California **within 60** days of your receipt of Blue Cross of California's first-level appeal decision.

Appeals Determinations

Pre-Service and Post Service Claim Appeals

You and your network provider will be provided written notification of Blue Cross of California's decision on your appeal as follows:

- For appeals of **pre-service claims,** Blue Cross of California will conduct the first-level review and notify you of its decision within 15 days of receipt of your request to appeal the denied claim. If you request a second-level appeal review, Blue Cross of California will also conduct this review and notify you of its decision within 15 days of receipt of your request for a second-level appeal review.

- For appeals of **post-service claims,** Blue Cross of California will conduct the first-level review and notify you of its decision within 30 days of receipt of your request to appeal the denied claim. If you request a second-level appeal review, Blue Cross of California will also conduct this review and notify you of its decision within 30 days of receipt of your request for a second-level appeal review.

Please note that Blue Cross of California's decision is based only on whether or not benefits are Covered Health Services as defined by the appropriate medical plan. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals the Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- Your appeal does not need to be submitted in writing. You or your physician should call Blue Cross of California at 1-800-274-7767 as soon as possible. Blue Cross of California will provide you with a written or oral determination within 72 hours following receipt of your request for review for review of the determination, taking into account the seriousness of your condition.

If you are not satisfied with the claims and appeals review completed with Blue Cross of California you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") or use PG&E's Voluntary Review Process (see below). However, before you can take civil action, you must go through both levels of appeal provided.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with Blue Cross of California, you may elect to either bring civil action or use PG&E's Voluntary Review Process. You have 90 days from the date of receipt of the final decision from Blue Cross of California to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring an ERISA action against the plan.

Step 1

The first step of the Voluntary Review Process is to write to the Benefits Department, requesting to review your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a Release of Confidentiality. This may be obtained from PG&E's intranet at www.hr or by calling the HR Service Center at the appropriate phone number listed on page 8. You should send your appeal to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N3K
Appeals
P.O. Box 770000
San Francisco, CA 94177

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the Release of Confidentiality may delay your appeal). There may be special circumstances where an extension of up to 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

If your claim deals with specific medical issues, the Benefits Department may suggest that your claim be submitted to an External Review Program as part of the first step of the Voluntary Review Program. The External Review Program entails having an independent third party

review the claim in question. This program only applies if the decision is based on either of the following:

- clinical reasons such as previous denials for custodial care or cosmetic services; or
- The exclusions are for Experimental or Investigational Services.

The External Review Program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. The External Review Program is optional, and its costs are paid by the plan. If the External Review Program recommends that the claim be covered, the Benefits Department will abide by the recommendation of the External Review Program.

Step 2

The second step of the Voluntary Review Process is to submit your appeal to an independent neutral third party for review. The third-party reviewer will be selected from a predetermined panel of arbitrators familiar with benefits law. You have the option of submitting the same written appeal prepared for Step One or may choose to supplement the Step One write-up with additional written material. The neutral third party will issue a written decision within 45 days of receipt of the appeal documentation. The neutral third party's decision shall be final and binding on the company, but not on you.

You have 60 days to exercise the second step of appeal. Send your written appeal with any additional information to:

Pacific Gas and Electric Company
Benefits Department, Mail Code N2P
Appeals – Step Two
P.O. Box 770000
San Francisco, CA 94177

If you would like more information regarding the Voluntary Review Process, you can write to the PG&E Benefits Department or call the PG&E HR Service Center at the appropriate number listed below.

PG&E HR Service Center

Active Employees: Company extension 223-2363, 415-973-2363 or 1-800-788-2363
Retirees and Surviving Dependents: 1-800-700-0057