Aetna Medical Claims Appeal Process

If you disagree with a medical claim decision, you may request Aetna re-review the claim. This process is called an appeal. You or an authorized representative (including a provider) may submit an appeal verbally or in writing.

You may submit up to two internal appeals: Level I and Level II. An internal appeal is reviewed by an Aetna Medical Director. A Level I appeal is your initial appeal. If your Level I appeal is denied, you may submit a Level II appeal, which must include additional or new information that was not included in your Level I appeal. Level I and II appeals are reviewed by different Aetna Medical Directors.

If your Level II appeal is denied, you may request an external review of your claim by an External Review Organization (ERO), an independent third party. All decisions made by Aetna or an ERO are final; Inova cannot override a denied claim or request that a claim be reprocessed at a higher benefit tier.

The Appeal Process

Information on how to submit an appeal is included in the Aetna medical plan booklet, which is available in the *Resources* section on the Inova Benefits Portal (www.myinovabenefits.org). The information below is a summary of the information contained in the *Complaints, Claim Decisions and Appeals Procedures* section of the Aetna booklet.

What reasons can I submit an appeal?

- The claim was denied in part or in full; OR
- The claim was processed incorrectly as out-of-network; OR
- The claim was processed at an incorrect benefit tier level; OR
- The claim was processed at an incorrect benefit tier due to a "network deficiency", which is the unavailability of a network provider for the member's condition within a 45-mile radius of the member's home zip code

What should I include in my appeal submission?

- Your name, date of birth, and address
- Your Member ID number
- The Group ID number and the Group Name – Inova Health Systems
- The name of the family member whose claim was processed incorrectly
- The Explanation of Benefits (EOB) document that shows how the claim was processed

- Any other claim documents, records, or other facts you would like Aetna to consider. This could include new details that were not presented initially.

Types of Appeals

The Explanation of Benefits is a document that shows how a claim was processed, i.e., what the medical plan paid and what you paid as a deductible, copay or coinsurance. If any or all of a claim is denied, it is called an “adverse benefit determination” or “adverse decision”.

Before You Appeal

You have the right to view the relevant documents Aetna used to make its decision on your claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may request the documents (free of charge) by calling or writing Aetna. You have 180 days from the time you receive this explanation to submit a Level I appeal.

Level I Appeal

A Level I appeal is your initial appeal, and you must submit it within 180 calendar days from the time you receive the notice of an adverse benefit determination on the Explanation of Benefits. Aetna will communicate the Level I appeal decision in writing within 30 days of receiving the appeal.

Submit your Level I appeal verbally or in writing:

- Call Aetna Member Services Department at 1-800-862-5441
- Mail your written request to:
  Appeals Resolution Team
  PO Box 14463
  Lexington, KY 40512
- Submit a request on https://health.aetna.com/
  - Go to the Support tab and select Send Message

If you do not agree with the outcome of the Level I appeal, you may submit a Level II appeal within 60 days from the date of the Level I decision.

Level II Appeal

A Level II appeal must be submitted within 60 days from the date of the Level I decision, and it must include additional or new information that was not included in your Level I appeal. Aetna will communicate the Level II appeal decision in writing within 30 days of receiving the initial appeal request.

Submit your Level II appeal verbally or in writing:

- Call Aetna Member Services Department at 1-800-862-5441, OR
- Mail your written request to:
  Appeals Resolution Team
  PO Box 14463
  Lexington, KY 40512

If you do not agree with the outcome of the Level II appeal, you may request an external review of your claim by an External Review Organization (ERO), an independent third party. Instructions on how to request an external review of your claim will be sent with the Level II appeal decision.

External Review
If Aetna continues to deny the payment, coverage, or service requested or you do not receive a timely decision, you may request an external review of your claim by an External Review Organization (ERO), an independent third party that is unrelated to Aetna. Your request must be submitted within 123 calendar days (four months) of the date you received the Level II appeal decision. The ERO will review the denial and issue a final decision. Aetna will advise you of the ERO's decision not more than 45 calendar days after receipt of all information required for the external review.

You have a right to an external review only if:
- Aetna's claim decision involved medical judgment
- Aetna decided the service or supply is not **medically necessary** or not appropriate.
- Aetna decided the service or supply is **experimental or investigational**.
- You received an adverse determination.

Submit your External Review request in writing to Aetna:

- Complete the *Request for External Review Form*
- Include a copy of the adverse benefit determination notice from Aetna
- Include all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. Aetna will pay for information it sends to the ERO plus the cost of the review.

Appendix A
Inova Medical Plan Benefit Tiers

Tier	Tier Name	Description
1	Maximum Savings	**Inova** providers, facilities and hospitals
2	Standard Savings Plus	Custom network by Innovation Health using Signature Partners, Valley Health, Privia, Loudoun Medical Group, Lyra Health and certain Aetna Behavioral Health providers
3	Standard Savings	Providers, facilities and hospitals contracted with Aetna
4	Out-of-Network	Providers, facilities and hospitals not contracted with Aetna The following hospitals in northern Virginia are out-of-network, except for emergencies: ▪ **Reston Hospital Center*** 1850 Town Center Pkwy. Reston, VA 20190 ▪ **Virginia Hospital Center*** 1701 North George Mason Drive Arlington, VA 22205 ▪ **StoneSprings Hospital*** 24440 Stone Springs Blvd. Dulles, VA 20166

*Aetna may consider approving these three out-of-network facilities at the Standard Savings tier if:

- A provider has exclusive admitting privileges at one of these facilities and no privileges at any Inova or In-Network Aetna facility, and
- A procedure is being done that cannot be done anywhere else with a participating provider and facility.

Providers may also submit an appeal. Providers have 180 days from receipt of the denied claim to submit their request for it to be considered timely. If the claim is eligible for reconsideration, it must have the reconsideration done before it is eligible for an appeal. Once the reconsideration is done, the provider has 60 days to file an appeal.

Appendix A (cont.)
Inova Medical Plan Benefit Tiers

The Inova medical plans have four benefit tiers as shown in the chart above.

1. The **Maximum Savings** tier is designed to encourage the use of Inova providers, which saves the company money or generates revenue. This is a business decision that is common among health care systems.

2. The **Standard Savings Plus** tier encourages the use Inova partners.

3. The **Standard Savings** tier is providers, facilities and hospitals in Aetna's national network.

4. The **Out-of-Network** tier is providers, facilities and hospitals that are not contracted with Aetna.

An appeal to request a claim be reprocessed at the Maximum Savings tier for services received by a non-Inova provider, facility or hospital will **not** be approved for any reason.

- Example 1: A team member resides outside of Virginia and does not have access to an Inova provider, facility or hospital

- Example 2: A team member resides in northern Virginia and an Inova provider, facility or hospital is not available to treat the team member's condition

For the above examples, Aetna may decide to reprocess the claim at the Standard Savings or Standard Savings Plus tiers, depending on the circumstance.