AETNA APPEAL PROCESS
For State of Delaware's Aetna Health Plans

OFFICE OF MANAGEMENT & BUDGET
STATEWIDE BENEFITS OFFICE

You may supply additional information that you would like us to consider. In addition, you may request copies of documents relevant to your claim (free of charge) by contacting us at the number on your member identification card. You are not responsible for the cost of the review or any filing fees.

INITIAL SERVICE

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

IF DENIED,

LEVEL I APPEAL – ADMINISTERED BY AETNA

2. Employee must file an appeal with Aetna within 180 calendar days from receipt of the notice of denial to request a second review of the claim.
3. Aetna approves or denies the appeal with written notice to the employee
    a. Within 15 calendar days for Pre-Service,
    b. Within 30 calendar days for Post-Service requests, or
    c. Within 36 hours for expedited appeals under certain conditions. In the event that the denial of an expedited appeal is upheld, the employee will have the option to skip the Level II Appeal and move directly to a Level III Appeal to the Statewide Benefits Office or External Review.

IF DENIAL IS UPHELD,

LEVEL II APPEAL – ADMINISTERED BY AETNA

4. Employee must file a Level II appeal within 60 calendar days from receipt of the notice of denial of the Level I appeal.
5. Aetna approves or denies the appeal with written notice to the employee
    a. Within 15 calendar days for Pre-Service requests,
    b. Within 30 calendar days for Post-Service requests, or
    c. Within 36 hours for expedited appeals under certain conditions.

IF DENIAL IS UPHELD,

LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATEWIDE BENEFITS OFFICE (SBO) AND/OR AETNA

For medical judgment or necessity, including care that is cosmetic or experimental, the employee may choose to file a Level III voluntary appeal to the SBO and/or an appeal administered by Aetna.

VOLUNTARY APPEAL TO THE STATEWIDE BENEFITS OFFICE

a. 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 (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal).

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
97 Commerce Way, Suite 201
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), and any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with the 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 Aetna and the SBO's Health Plan Appeal Form and Checklist, both of which are available at **www.ben.omb.delaware.gov/medical/aetna.**

Employees submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. Statewide Benefits Office will not begin to review the appeal until the Authorization Form and the Appeal Form and Checklist are received. Statewide Benefits Office will not begin to review 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 the carrier within 30 days of receiving the appeal.

Note: The one hundred twenty day timeframe for requesting an external appeal begins upon receipt of the Level II denial or if the appeal is an expedited appeal and the Level II is skipped, the 120 day time frame should begin upon receipt of the

Level I denial, regardless of whether or not a Level III appeal is requested. By choosing to request a Level III appeal with the Statewide Benefits Office, the time may expire for you to request an External Appeal review with Aetna.

EXTERNAL REVIEW PROVIDED VIA AETNA

b. Employee may request an external review for decisions involving medical judgment or necessity, including care considered to be cosmetic or experimental care by contacting Aetna and requesting a Request for External Review form. An external review is performed by independent physicians with expertise in the medical service or supply at issue. Upon completion of the external review, Aetna accepts the decision of the external reviewer, however, you may file an appeal denial to the Statewide Benefits Office and/or the State Employee Benefits Committee. Your request for an External Review must be returned to Aetna within 120 calendar days from receipt of the notice of denial of the Level II appeal or if the appeal is an expedited appeal and the Level II is skipped, the 120 day time frame should begin upon receipt of the Level I denial (or receipt of the notice of denial of the Level III appeal by the Statewide Benefits Office, if applicable) to the address appearing on the form.

IF DENIAL IS UPHELD BY EITHER THE STATEWIDE BENEFITS OFFICE OR AETNA'S EXTERNAL REVIEW CARRIER

LEVEL IV (FINAL) APPEAL – ADMINISTERED BY THE STATE OF DELAWARE – STATE EMPLOYEE BENEFITS COMMITTEE

6. 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 Level III appeal.

Chair, State Employee Benefits Committee (SEBC)
RE: APPEAL
Office of Management and Budget
Haslet Armory, Third Floor, Suite 301
122 Martin Luther King Boulevard, South
Dover, DE 19901

7. 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 you have questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272)