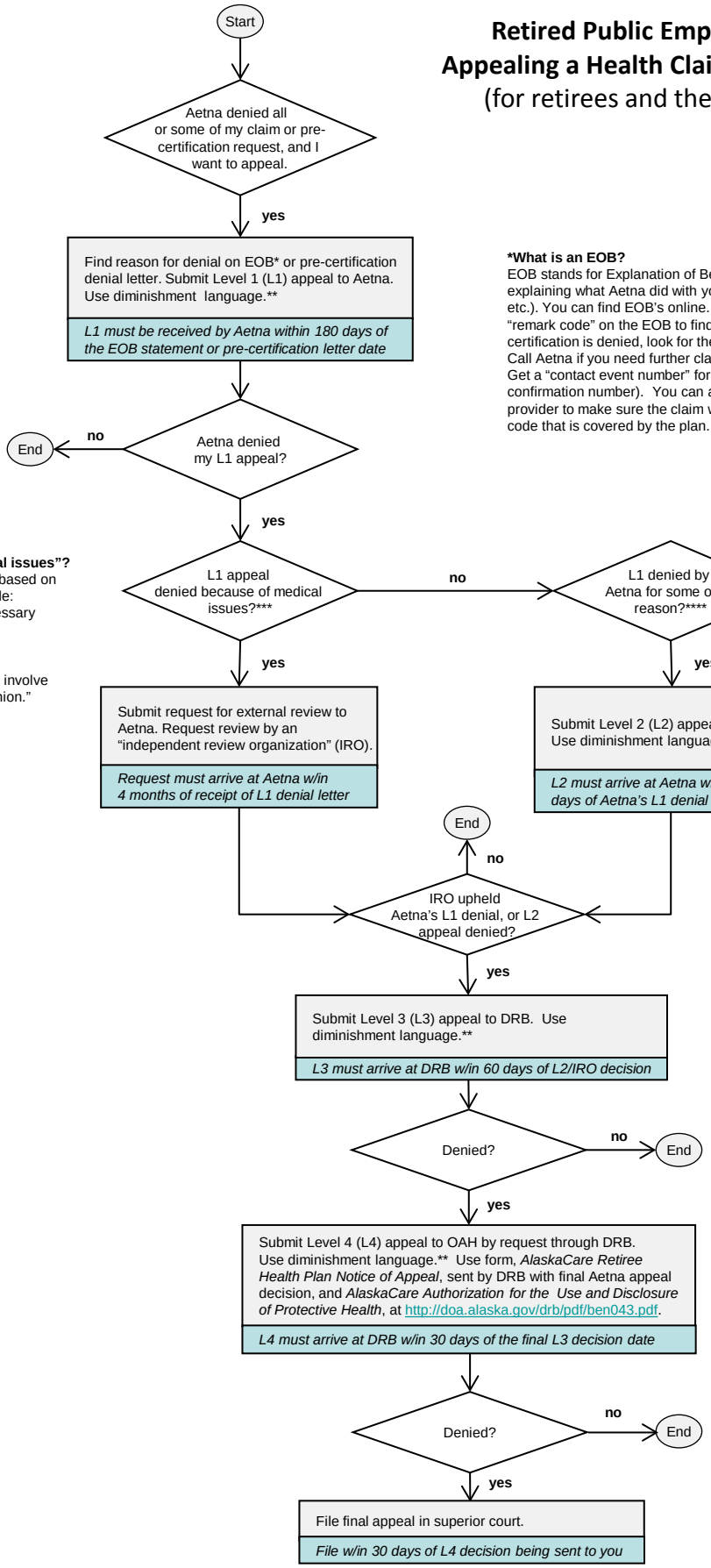
Retired Public Employees of Alaska (RPEA)
Appealing a Health Claim or Precertification Denial
(for retirees and their dependents) Rev. 4/18



***What is an EOB?**
EOB stands for Explanation of Benefits. It is a statement explaining what Aetna did with your claim (covered, denied, etc.). You can find EOB's online. If denied, look for the "remark code" on the EOB to find the reason. If pre-certification is denied, look for the reason in the denial letter. Call Aetna if you need further clarification at 1-855-784-8646. Get a "contact event number" for your call (this is like a confirmation number). You can also contact your health provider to make sure the claim was correctly coded using a code that is covered by the plan.

*****What are "medical issues"?**
Examples of denials based on medical issues include:
- Not medically necessary
- Level of care
- Experimental
- Investigational

These are things that involve Aetna's "medical opinion."

******What other reasons?**
Some examples include coverage (the plan doesn't cover the particular procedure); the provider charged more than the "recognized charge"; or the plan covered this service in the past but is denying now (diminishment).

****What is the Diminishment Language?**
As a former state employee, your contract for health care coverage and other benefits is protected by law. However, the State unilaterally changed those benefits in January 2014 in a way that impermissibly diminishes them without an equal or greater offsetting of enhanced benefits.

RPEA has been working to monitor and address these changes. Part of that work includes monitoring medical and dental claim denials by Aetna and Moda to ensure these changes are properly addressed. RPEA suggests that you appeal any claim denied by Aetna or Moda for a health service you received, and that was covered, before January 2014. RPEA provides detailed instructions for filing medical and dental appeals and suggested language to use in any appeal you file so that the 'diminishment of benefits' claim is made for you and others. You can find the forms to file medical and DVA appeals on the RPEA website at: rpea.apea-aft.org. Or use the "hot-links" in the instructions to copy the wording. The recommended language is presented on the next page.

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WHERE TO SUBMIT YOUR APPEALS AT EACH LEVEL

Level 1 (all issues)
Mail or fax to: Aetna – keep fax or certified mail receipt
ATTN: AlaskaCare Member Appeal Level I
P.O. Box 14463, Lexington, KY 40512-4463
FAX: (859) 425-3379

Level 2 (for plan design or claim denial)
Mail or fax to: Aetna – keep fax or certified mail receipt
ATTN: AlaskaCare Member Appeal Level II
P.O. Box 14463, Lexington, KY 40512-4463
FAX: (859) 425-3379

Request for IRO (if L1 denied for medical issues)
Mail to: Aetna – keep fax or certified mail receipt
ATTN: National External Review Unit
2000 River Edge Parkway, Suite 300
Atlanta, GA 30328

Level 3-Div. of Retirement & Benefits (DRB) Appeal
Mail to: State of Alaska (with certified mail receipt)
Division of Retirement and Benefits Health Appeals
P.O. Box 110203
Juneau, AK 99811-0203

Level 4--Office of Admin. Hearings (OAH) thru DRB
Mail to: State of Alaska (with certified mail receipt)
Division of Retirement and Benefits Health Appeals
P.O. Box 110203
Juneau, AK 99811-0203
You must request DRB to file the appeal with OAH You may not file an appeal directly with OAH. The appeal is due within 30 days of the date of your level 3 appeal decision. Written request to appeal any medical claim denial to the DRB at one of its offices (Juneau, Anchorage, or Fairbanks).

Two forms must be used to submit an appeal to OAH:
1. *AlaskaCare Retiree Health Plan Notice of Appeal*, and
2. *AlaskaCare Authorization for the Use and Disclosure of Protective Health.*

All other documents must be typed or printed on 8.5 x 11" white paper and include the following:
- Your name, address, and telephone number.
- Date of the decision being appealed
- Name and address of DRB (above)
- Brief statement of the issue for OAH to review

OAH has 120 days from receiving the appeal decision to make a decision and forward to DRB.

URGENT L1 or 2 APPEALS:
If your medical provider decides that a delay in a procedure could harm your health, you and your provider can contact Aetna Patient Care Management at 1-800-333-4432 to request an expedited appeal.

Aetna should respond **no later than 72 hours** after receiving your Level 1 or Level 2 expedited appeal.

** DIMINISHMENT LANGUAGE

I am appealing the denial of coverage for _____ provided to me on _____, 20__. The State of Alaska provides health benefits for individuals, including retirees, who are entitled to coverage under applicable statutes. These benefits are described in the Retiree Health Plan Booklet and include benefits under DVA for retirees who elect coverage. The benefits provided under this coverage cannot be diminished without an equal or greater offset of enhanced benefits.

- When I (or my spouse) retired in _____, I was/we were entitled to receive medical coverage under the Retiree Health Plan. I was entitled to elect DVA coverage.
- The medical and DVA benefits provided under this coverage are described in the 2003 Retiree Insurance Information Booklet prior to the 2014 Amendments.
- I elected to pay for DVA coverage through monthly withholdings from my monthly retirement payment.
- I am entitled to receive the medical or DVA benefits and coverage as implemented under the Retiree Health Plan prior to the 2014 Amendments, which constituted an impermissible diminishment of benefits.
- PERS/TRS retirement benefits, including medical and DVA benefits, are vested, constitutionally protected rights that cannot be diminished without an equal or greater enhancement.
- DOA has unilaterally diminished benefits and coverage as described in the 2003 Retiree Benefits Booklet such as treatment for _____, and has not provided any enhanced benefits under the Retiree Health Plan to offset these diminished benefits.

Attached are the details of my appeal and supporting documents.

MORE DETAIL ABOUT FILING DEADLINES

L1 Appeal Filing Deadline Must be received by Aetna within **180 calendar day**s of the date that the EOB or pre-certification letter was issued. Use this tool for an easy date calculator: http://cgi.cs.duke.edu/~des/datecalc/datecalc.cgi or click here. It is recommended that you use the Recommended Cover Page Language – see Medical, Vision and Audio Appeal Instructions on the RPEA website. Aetna must respond to precertification denials within 15 calendar days and not eligible for IRO review or 30 days if eligible. It must respond to claim appeal denials within 30 calendar days if not eligible for IRO or 60 days if eligible.

L2 Appeal Filing Deadline L2 appeals of medical issues must be received by Aetna within **4 months** of the date the L1 decision letter. Appeals of plan or policy issues must be received by Aetna within **180 calendar days** of the date the L1 decision was issued. Use this tool for an easy date calculator: http:// cgi.cs.duke.edu/~des/datecalc/datecalc.cgi. Aetna is required to respond to an appeal regarding precertification within **15 days**, or within **30 days** for all other appeals. The IRO will provide written decision within **45 days** after receiving the request for review.

L3 Appeal Filing Deadline Must be received by DRB within **60 calendar day**s of the external review or L2 decision date. Use this tool: http://cgi.cs.duke.edu/~des/datecalc/datecalc.cgi. DRB must issue a written decision of your level 3 appeal within 60 calendar days from receipt of your appeal.

L4 OAH Filing Deadline Must be received by DRB within **30 days** of the date of the final L3 decision. You may not file an appeal directly with OAH. Once an appeal is filed, you will be notified by OAH. OAH has **120 days** after receipt of the appeal to prepare a proposed decision. 2AAC 64.110-340.

Appeal to Superior Court Filing Deadline Must be filed with the Superior Court within **30 days** after the date the decision you are appealing is mailed or otherwise distributed to you.