Health Plan Appeal

For services incurred on or after January 1, 2018

Guide for Members of the AlaskaCare Retiree Health Plan

Introduction

The AlaskaCare Retiree Health Plan provides members with the right to appeal the health claims and precertifications that have been denied by the claims administrator, Aetna.

If a claim or precertification is denied, in whole or in part, your Explanation of Benefits (EOB) or letter from Aetna will explain the reason for the denial. Please refer to your *Retiree Insurance Information Booklet* for coverage information and if necessary, call Aetna toll-free at (855) 784-8646 for further clarification. If you still feel the claim or precertification should be covered under the terms of the Plan, you may take the following steps to file an appeal.

NOTE: See the Dental Plan Appeal brochure (ben074b) for information on dental appeals.

Level I – Claims Administrator Appeals

Please submit your request in writing, explaining the nature of your appeal, including copies of the Aetna Member Complaint and Appeal Form (optional), EOBs, correspondence, and pertinent medical records. Your appeal must be received by Aetna within 180 calendar days of the date the EOB or precertification denial letter was issued. Submit your request to the following address:

Aetna
Attention: AlaskaCare Member Appeal Level I
P.O. Box 14463
Lexington, KY 40512
Fax: (859) 425-3379

If appealing a precertification denial, Aetna will issue a written decision within 30 calendar days after their receipt of your appeal. If your precertification denial is not eligible for external review, Aetna will issue a written decision within 15 calendar days after their receipt of your appeal. If appealing a claim denial, Aetna will issue a written decision within 60 calendar days (30 calendar days if not eligible for external review) after their receipt of your appeal. If you are not satisfied with the Level I decision, you may submit a Level II appeal to Aetna. See instructions for Level II Appeal.

Level II – Claims Administrator Appeals (Administrative)

You may request a Level II appeal if your claim is not eligible for external review. Aetna must receive your written request for a Level II appeal within 180 calendar days of the date the Level I decision letter was issued. Submit your request to the same address as the Level I appeal, but with the indication that it is a Level II appeal.

Your appeal will be reviewed by individuals who did not participate in the Level I review and Aetna will issue a written decision within 15 calendar days for precertification appeals or within 30 calendar days for post service appeals.

Independent Review Organization (Clinical in Nature)

If your denied claim relates to benefits that involve medical judgment (e.g. medical necessity or level of care), you may file a request for external review no later than 4 months following receipt of your Level I denial. The Independent Review Organization (IRO) will provide written notice of its decision within 45 calendar days. If the external review organization decides the medical issues in your favor, the plan will pay immediately.

The Claims Administrator will send you a separate appeal response letter, in addition to the IRO's letter, explaining your Level III appeal rights and directions.

If you are not satisfied with the final Level II or IRO decision, you may appeal this decision to the Division of Retirement and Benefits.

URGENT APPEALS: If your doctor or provider advises Aetna that a delay in your appeal process could harm your health, Aetna will reach a decision regarding your appeal within 72 hours after receipt of your Level I or Level II appeal.

Level III – Division of Retirement and Benefits Appeal

You may request a Level III appeal in writing, explaining the nature of your appeal and submitting any additional documentation from your provider not previously submitted.

Your appeal must be received by the Division within 60 calendar days of the date of the Level II or IRO decision. The Division will issue a written response within 60 calendar days after receipt of all relevant material. If you are not satisfied with the Division decision, you may appeal this decision to the State of Alaska's Office of Administrative Hearings. See instructions for Level IV Office of Administrative Hearings Appeal below.

Level IV – Office of Administrative Hearings Appeal

Please submit your request and the following forms to the Division of Retirement and Benefits within 30 calendar days of the date of the final Level III decision:

- AlaskaCare Retiree Health Plan Notice of Appeal
- AlaskaCare Authorization for the Use and Disclosure of Protected Health Information (PHI)

Please send this material to:

State of Alaska
Division of Retirement and Benefits
Attention: Health Appeals
P.O. Box 110203
Juneau, AK 99811-0203

Your appeal file and any additional documentation submitted in support of your appeal will be forwarded to the Office of Administrative Hearings (OAH) within 15 calendar days after receiving your request. (AS 39.35.006)

NOTE: Details regarding OAH appeals can be found in the brochure titled *Office of Administrative Hearings* available upon request from the Division of Retirement and Benefits.

If you are not satisfied with the final OAH decision, you may appeal to the Superior Court.

AlaskaCare
Retiree Health Plan

Alaska Division of Retirement and Benefits

6th Floor, State Office Building | 333 Willoughby Ave. | P.O. Box 110203 | Juneau, AK 99811-0203

Member Services Contact Center
Hours: Monday-Thursday 8:30 a.m. - 4 p.m. | Friday 8:30 a.m. - 3 p.m.
Toll-Free: (800) 821-2251 | In Juneau: (907) 465-4460 | Fax: (907) 465-3086 | TDD: (907) 465-2805
alaskacare.gov | doa.drb.mscc@alaska.gov

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