IMPORTANT ANNUAL NOTICE

In compliance with state of Rhode Island laws, we have posted this notice to explain provider and member complaint and appeal rights. These rights apply to complaints and appeals involving concerns and claims for our commercial fully insured plans.

This section of the annual notice covers complaints and appeal procedures for providers.

Provider complaints
If you are a provider and not satisfied with our administrative services or the quality of services we provide, you may contact us for help or to submit a complaint.

To make a verbal complaint: Call our Provider Service Center at: **1-888-632-3862** or **1-888-MD-Aetna (TTY: 711)**.

To send us a written complaint: Fill out our complaint and appeal form here. Send the form to us at:

Aetna
Provider Resolution Team
PO Box 14020
Lexington, KY 40512

You should include a description of the issue, and copies of any relevant records or documents. We will review it and send you a written response within 30 calendar days of receiving your written complaint. We'll let you know if we need more information to make our decision.

Provider claim reconsiderations/Appeals

If you are a provider, you may dispute claim decisions on your own by submitting a claim reconsideration request to us. The reconsideration request should be sent to us within 180 days of the claim decision issued on the explanation of benefits notice.

You can also ask for a claim reconsideration by phone, online or by fax. Contact information is posted on **Aetna.com** at:

Aetna.com/faqs-health-insurance/health-care-professionals-dispute-process-faqs.html

After a reconsideration, you may submit an appeal if you disagree with the decision. There is one level of provider appeal available.

Please send your appeal within 60 days of the claim reconsideration decision and use our complaint and appeal form here. Send your completed appeal to:

Aetna
Provider Resolution Team
PO Box 14020
Lexington, KY 40512

We'll send our appeal decision within 60 calendar days after we get your appeal.

Member authorized representative

You may act as the member's authorized representative for the member appeal process. Notify your patient if you plan to act as their designee in the member appeal processes. We describe this process on the next page.

This section of the annual notice explains member rights under Rhode Island state law for reviews of benefit determination appeals, and complaints and grievances.

What is the difference between a complaint and an appeal?

Complaints

If a member is not satisfied with a provider or with administrative services, they may contact us for help

- To file a verbal complaint, a member can call Member Services at the phone number on their member ID card.
- To file a written complaint, a members can send it to:
  Aetna
  PO Box 14586
  Lexington, KY
  40512-1486

The member should include a description of the issue, and copies of any records or documents that are relevant. We'll review this and send the member a written response within 30 calendar days of receiving the complaint. We'll let the member know if we need more information to make our decision.

Appeal

We may decide to deny a claim — or only pay a part of it. When we do this it's called an adverse benefit determination. If a member disagrees with our decision, they can ask us to review it again. This is called an appeal. A member can start the appeal process by contacting us at the phone number on their member ID card. Another person, such as their doctor, may submit an appeal for them. That person is called an authorized representative.

Claim decisions

A member's provider may contact us to file a claim. Or the provider may ask approval for payment, based on the member's benefits. This could be before, during, or after the member receives care. The member may not agree with our decision. We pay many claims at the full rate (The member still must pay costs such as their deductible and copays). In some cases, we may pay only some of the claim or deny payment entirely. This can depend on the member's health plan.

If we deny part or all of the claim, it's called an "adverse benefit determination" or "adverse decision."

- A non-administrative adverse benefit determination involves clinical matters. For example, we may not cover care because we decided it was not medically necessary.

  We don't make this kind of a decision until a licensed doctor who is qualified to evaluate the member's condition has consulted with their doctor.
- An administrative adverse benefit determination is a non-clinical decision. For example, the service may not be covered under the member's plan.

Internal appeal process

For any adverse decision, we'll send the member an explanation of benefits, in writing. The member can ask us to review our decision again. This is called an internal appeal. Members must file an appeal with us within 180 calendar days from the time a member receives the notice of an adverse benefit determination.

Time frames for deciding appeals

The amount of time that we have to notify members of our decision on an appeal claim depends on the type of claim. The chart below shows different types of claims and how much time we have to notify members of our decision.

Type of notice	Time frame
Administrative appeal	Pre-service = 30 days Post-service = 60 days
Non-administrative appeal	Pre-service = 30 days Post-service = 30 days Urgent care/Pre-service = 72 hours
Concurrent review appeals	Expedited = 72 hours Non-expedited = 30 days
Pharmacy non-formulary drug appeals	Within 72 hours of a non-urgent claim. Within 24 hours if member is undergoing a current course of treatment with a non-formulary drug. Within 24 hours if member's prescriber determines that a members is suffering from a health condition that may seriously jeopardize a member's life, health, or ability to regain maximum function. Pharmacy/Other = standard time frames as listed under "non-administrative appeal."

How to ask for an internal appeal

Members can send a written appeal to the address on the notice of adverse benefit determination. Or members can call us at the phone number on their ID card. Members need to include:

- Their name or the policyholder's name
- A copy of the adverse benefit determination
- Their reasons for making the appeal
- Any other information they would like us to consider

We'll assign their appeal to someone who was not involved in making the original decision.

For questions, complaints or help with a member appeal, contact the Office of the Health Insurance Commissioner. Contact the Rhode Island Insurance, Education, and Assistance Consumer Helpline (RIREACH) at **RIREACH.org** or **1-855-747-3224.**.

External review process

A member can ask for an external review after the member has completed the internal appeal process with us. This review is done by an independent review organization (IRO). They will assign the case to a reviewer who is a doctor with expertise in the area in question.

Rhode Island external review legislation states that members have a right to external review only if all these conditions are met:

- A member has received an adverse benefit determination
- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate — or that it's experimental or investigational

We'll let members know if they meet those conditions when we send them the adverse benefit determination notice.

We'll also include:

- A copy of the request for external review form for the final adverse determination
- A description of the external review process

How to submit the request for external review form:

- Members need to send it to us within four months of the date they received the adverse decision notice.
- They should include a copy of the notice and any other important information that supports the request.
- The member will have to pay for any pre-review costs, but their costs will not exceed $25 per review or $75 per year.

IRO process

We will:

- Pay for sending the information to the IRO plus the cost of the review
- Contact the IRO that will review the claim within five business days of receiving the request
- Let the member know that their IRO request for an external review has been sent to IRO

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider information that member sent
- Follow our contractual documents and member plan of benefits
- Send us their decision within 10 days of receiving all necessary information and no more than 45 days after receiving the request for external review. For urgent care appeals, the IRO will send us their decision within 72 hours of receiving the request for external review.

We'll stand by the IRO 's decision unless we can show conflict of interest, bias or fraud.

Record keeping

We'll keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by member in pursuing a complaint or appeal.