



Customer Resolution Team
PO Box 14464
Lexington, KY 40512

August 27, 2010

[REDACTED]

Subscriber Name: [REDACTED]
Member Name: [REDACTED]
Member ID: [REDACTED]
Provider Name: [REDACTED]
Date of Service: [REDACTED]
Patient Account Number: [REDACTED]
Payer: Aetna Life Insurance Company
Case Number: [REDACTED]

Subject: Level 1 Appeal Decision

Dear [REDACTED]:

This letter is in response to the appeal request we received on [REDACTED]. This appeal is about the denied mammogram performed by [REDACTED] on [REDACTED].

We reviewed all available information, including:

- Your verbal appeal request,
- the original claim and
- your benefit booklet.

Our decision

Based on our review of the above information, we are upholding the previous decision to deny the mammogram.

How we made our decision

In your appeal request, you indicate the mammogram was performed because of your increased breast tissues caused by hormone injections.

Under the Plan, benefits for services related to sex change are not covered. According to your Plan, "Any treatment, drug, service or supply related to changing sex or sexual characteristics" is excluded from coverage.

This denial of coverage is based solely upon the reasons set forth above. No other basis for exclusion (e.g., medical necessity of the service or supply) that may be applicable to the circumstances was evaluated at this time.

Under your Managed Choice Point of Service, listed under **Medical Plan Exclusions**, it states:

“Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling”

We regret our determination could not be more favorable; however we are bound by the terms of the contract.

The following individual(s) were involved in the review of your appeal:

- A complaint and appeal analyst, who was not involved in the original decision.
- A complaint & appeal nurse analyst, who was not involved in the original decision.
- A medical director, board certified in Family Medicine and Geriatrics who was not involved in the original decision.

Access to relevant documents

At your request, we will give you free of charge access to copies of all documents, records, and other information about your claim for benefits, including the specific rule, guideline, protocol, or other similar criterion that was used in making the decision, and the names of any clinical reviewers if applicable.

Next Steps

If you disagree with this decision, you may request a second level appeal. If you choose to appeal, please forward any additional relevant information that you would like us to consider. Please refer to the enclosed document entitled “Aetna Appeal Process and Member Rights” for complete instructions and for an overview of the entire appeal process.

We are here to answer your questions

If you have further questions about this appeal decision or the appeal process, please call Member Services at the number on the member ID card. Please include the case number listed at the top of this letter when responding or inquiring about this issue.

We want to know!

Please visit our website for a short survey about Aetna's appeal process.

https://www.aetna.com/form_assets/members/survey.html

Thank you for giving us the opportunity to address your concerns.

Sincerely,



Carmen Matthews
Customer Resolution Team

Enclosure

Gen 4
Rev1_12.22.09

Please retain this document for future reference.

Aetna Appeal Process & Member Rights

As a member of Aetna, you or your authorized representative has the right to file an appeal about coverage for service(s) when you are not satisfied with the original coverage decision. Below is an overview of the entire appeal process and your legal rights. Refer to our response to your letter of appeal to understand where you are in the appeal process.

1. Appeals can be filed in writing to Aetna or by calling Aetna's Member Services Unit at the number on the member ID card. Appeals must be submitted within 180 calendar days from the date that you receive the original decision. After that, Aetna will consider the original decision to be final.
2. Aetna completes the appeal process and notifies you about each appeal decision within 30 calendar days of when we receive the appeal.
3. Second Level Appeal: If you disagree with the response in our first appeal resolution letter, you may request a second level appeal. To begin this process, you must send a request in writing to Aetna within 60 calendar days from the date that you receive the resolution letter. If you do not request a second level appeal within that time period, Aetna will consider the decision stated in the first resolution letter to be final.

If you do not agree with the final decision, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

4. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your plan administrator or local U.S. Department of Labor Office.