Aetna

Customer Resolution Team
P.O. Box 14462
Lexington, KY 40512

October 20, 2010

[redacted]

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

Subject: Final Appeal Decision

Dear [redacted]

This letter is in response to the appeal request we received on [redacted]. This appeal is about the mammogram provided by [redacted] on [redacted].

We reviewed all available information, including:

- The appeal,
- Claim information and
- The applicable plan information.

Our decision

Based on our review of the above information, we are upholding the previous decision to deny the mammogram provided by [redacted] on [redacted].

How we made our decision

In your appeal, you requested we reconsider the mammogram provided by [redacted] on [redacted]. You stated you identify as a female and you feel it is discriminatory to deny the mammogram. You stated the mammogram is not related to any sex change.

The following individuals who were not involved in the original determination or first level appeal were involved in the review of your appeal:

- A complaint and appeal analyst
- A complaint and appeal nurse consultant

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.

Our records indicate that you are enrolled in an Open Access Managed Choice health plan sponsored by [redacted] The Plan Booklet outlines the following:

"Medical Plan Exclusions
Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this Booklet.

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."

Our records indicate that your gender is male. The submitted procedure code is not consistent with your gender in our system. I regret my response cannot be more favorable. This decision is based on the terms of your plan material.

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
With this final decision, the appeal process within Aetna has been completed. Please refer to the enclosed document entitled "Aetna Appeal Process and Member Rights" for additional rights available to you 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,

Donna M. Cupitt

Donna M. Cupitt
Complaint and Appeal Analyst
Customer Resolution Team

Enclosure

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 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 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 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.