



EMORY
UNIVERSITY

Health Plan Appeals Process

Appeals related to: Eligibility for coverage, Participation and Contributions

Emory will make all determinations about written claims/appeals relating to eligibility for coverage, participation, contributions, or other administrative aspects of the Plan. Emory may require you to provide any information they decide is necessary to make a decision about your claim/appeal. First and second level appeals are accepted for consideration by Emory in regard to eligibility, participation and contributions.

How to File your Appeal

To have your given situation reconsidered, you must submit a formal written request within 180 days from receiving notification of a denial of eligibility for coverage, participation and/or contributions. This formal request is considered an appeal. Any appeal should be accompanied by documents, records or other information in support of your position. The appeal when reviewed will take into account all documents, records and other information you submit regarding your claim without regard to whether the information was considered in the initial benefit determination. The appeal will not give deference to the initial decision to deny the claim and will be conducted by an appropriate named fiduciary of the Group Health Plan. In addition to the documentation you submit, Emory will also research regulatory issues as well as Emory policy and procedures related to your request. In addition, any correspondence and access to self service which indicate your current or historical benefit elections, enrollment and payroll deductions will also be researched to determine if applicable to rendering a final decision with regard to your appeal.

Within 15 days of the receipt of your written appeal, the Benefits Department will notify you of its' receipt. Within this notice, you will also be notified of the timelines associated with a full and proper investigation and review of your appeal. The review will be conducted within a reasonable period of time, but not later than 30 days after receipt of your appeal. This period may be extended one time for up to 15 days, provided it is determined that such an extension is necessary due to matters beyond the control of the plan or the person(s) involved with reviewing the appeal. If an extension is required, you will be notified in writing prior to the end of the initial 30 day period. In no case will a review of a written appeal take more than 45 days from the day it is received to investigate and render a formal decision in writing.

Formal appeals may be submitted via regular mail to:

Emory University
Employee Benefits Department
1599-001-1AP
1599 Clifton Road NE
Atlanta, GA 30322

Formal appeals may also be submitted via Fax at:

Emory University
Employee Benefits Department
FAX: (404) 727-7145

**** Under no circumstances will an appeal be accepted via email ****



Appeals related to: Individual Claims Payments

For appeals related to claims payments under the health, dental and flexible spending accounts, Emory's contracted claims administrators have been delegated authority to accept first and second level appeals, review them and render decisions about claims payments relating to benefits paid or payable under the Plan.

Types of claim appeals:

- **Pre-Service Claims**

A "pre-service" claim means any claim for which a benefit under the Group Health Plan which requires approval from the plan before obtaining medical care in order for such medical care to be covered by the plan.

- **Urgent Care Claims**

An "urgent-care" claim means any claim involving a condition that is considered urgent because it could seriously jeopardize the participant's life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the person's medical condition, it would subject the person to severe pain that could not be adequately managed without the treatment or care being requested. Urgent care claim appeals have escalated review and response periods, please consult the plan's summary plan document for additional details.

- **Post Service Claim**

A "post-service" claim means any claim which involves payment for the cost of health care that has already been provided under the Group Health Plan.

How to File your Appeal

To have your given situation reconsidered, you must submit a formal written request within 180 days from receiving notice of the denial of the claim. This formal written request is considered an appeal. Please indicate in the body of your request if this is your first or second appeal in regard to this specific claim denial. Your appeal should be accompanied by documents, records or other information in support of your position. The appeal when reviewed will take into account all documents, records and other information you submit regarding your claim. The appeal will not give deference to the initial decision to deny the claim and will be conducted by a fiduciary of the Group Health Plan. In addition to the documentation you submit, claim administrator will also research regulatory issues as well as plan design related to your request. In addition, any correspondence and contact which has been recorded with the claims administrator will also be considered in rendering a final decision with regard to your appeal.

The review will be conducted within a reasonable period of time, but not later than 30 days after receipt of your appeal. This period may be extended one time for up to 15 days, provided it is determined that such an extension is necessary due to matters beyond the control of the plan or the person(s) involved with reviewing the appeal. If an extension is required, you will be notified in writing prior to the end of the initial 30 day period. In no case will a review of a written appeal take more than 45 days from the day it is received to investigate and render a formal decision in writing.

To submit your written appeal regarding a claim, contact the appropriate claims administrator at the appropriate address listed below:

Medical Plans:

For Aetna POS Plus, Aetna POS Value and HDHP contact:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512
Fax (859) 455-8650

Prescription Drug Coverage:

For Aetna HDHP contact Aetna at:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512
Fax (859) 455-8650

For Aetna POS Plus and Aetna POS Value contact Medco at:

Medco Health Solutions
8111 Royal Ridge Pkwy
Irving TX 75063 0000
ATTN: Coverage Appeal
Fax (888) 235-8551

Mental Health:

For Aetna POS Plus, Aetna POS Value and HDHP contact:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512
Fax (859) 455-8650

Dental Plans:

For Aetna Traditional or DMO Dental plans contact:

Aetna Appeals
P. O. Box 14597
Lexington, KY 40512

Flexible Spending Accounts:

For UMR contact:

UMR
Appeal Unit
P. O. Box 30546
Salt Lake City, UT 84130