



Aetna Life Insurance Company
PO Box 14876
Lexington KY 40512-4876

TOTAL LIPEDEMA CARE
240 South La Cienega Blvd. Suite 220
Beverly Hills, CA 90211

03/20/2024

Member Name: TAMI AHMAD
Member ID: W237480909
Member Date of Birth: 10/22/1961
Reference Number: 240305018802
Plan Sponsor: EMCOR GROUP, INC.
Plan Sponsor Account Number: 880794
Dates of Service: 03/05/2024 - 03/05/2025
Service Description: Liposuction

Dear Member and Healthcare Provider(s) of Record,

We have received and reviewed a request to cover services by a non-participating (out-of-network) provider at an in-network benefit level for the above member.

Coverage Decision:

We're not approving coverage at an in-network benefit level for services by the below non-participating provider. The information we received about the member's condition and circumstances shows that a participating (in-network) provider can provide the requested services. Check the member's benefit plan document for information about out-of-network coverage.

Non Participating Provider(s)
TLC SURGICAL CENTER

The following participating provider(s) are available to provide the requested services.

Participating Provider	Participating	Participating
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Name	Provider Address	Provider Telephone
Kyle XU	2801 Northwest 79th Avenue Miami, FL 33122	305-243-7500
Thomas Hagopian	99 Krog Street Northeast Unit C110 Atlanta, GA 30307	404-885-8542

Additional Coverage Information:

The member's plan has an out-of-network benefit level for the use of non-participating providers. If the member elects to use the services of the above non-participating provider, the out-of-network benefit level will apply. The member would be responsible for out-of-network cost sharing, such as a deductible and coinsurance, plus any charges by the provider in excess of the amounts covered by the plan. These excess amounts may be significant.

Information about Coverage Denials:

"Coverage" means whether or not a service or treatment is covered under the terms of the member's benefit plan or payable under the terms of the provider's agreement.

Our decision is limited to whether the health care services are covered under the member's benefit plan or provider agreement. The treating practitioner, in consultation with the member, remains responsible for deciding what treatment is appropriate and what services to provide.

The guideline, protocol, or criteria used to make this decision is available upon request by calling our Member Services department using the phone number displayed on the member's ID card.

Denial codes are not used and therefore not available.

Peer to Peer Review: If you are a treating practitioner and you disagree with a coverage denial, you may request a peer to peer review with the Medical Director who made the decision. To request a peer to peer review, call the Medical Director's phone number at the end of this letter. You must request this review within 14 calendar days from the date of this letter. A Medical Director will try to contact you within one business day of your request or at a time that you specify. A peer to peer review is optional and not an appeal. It is a focused discussion during which you may provide additional information and ask the Medical Director to reconsider the decision. If you are not satisfied with the outcome of this review, you may appeal the coverage denial as shown below. You may also appeal without a peer to peer review.

Provider Appeal Rights: You may appeal this coverage decision if you disagree. If this is a prospective or concurrent decision for services not yet provided or for ongoing services such as an inpatient stay, any appeal would be considered on behalf of the member. Please see the member appeal rights below. If this is a retrospective decision for services that have been completed, you may appeal within 180 days of your receipt of this denial notice. If you decide to

appeal, your appeal should include a copy of this denial notice, an explanation of the treatment rationale, and all supporting documents to be considered, including a copy of any pertinent medical records. To request an appeal on behalf of the member, follow the member appeal instructions below and clearly state that your appeal is on behalf of the member. If your appeal is not on behalf of the member, send your appeal to the following address: Aetna, Attn: Provider Resolution Team, P.O. Box 14020, Lexington, KY 40512.

Member Appeal Rights:

You may not agree with our decision. You or someone you choose to act for you (called your authorized representative) can ask us for a review (appeal). Do this by phone or in writing within 180 days (6 months) after you receive this letter. Some plans give more than 180 days to do this. See your plan brochure or other plan document, such as your Certificate of Coverage or your Summary Plan Description.

How to ask for an appeal by phone

Call Member Services. The toll-free telephone number is listed on your member ID card. If you are hearing impaired you can call 711 for Telecommunication Relay Services (TRS). Member Services can also help you with the process of naming an authorized representative.

How to ask for an appeal in writing

You or your authorized representative can send a letter or a completed Member Complaint and Appeal Form to the address below. The form is online at:
<https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf>.

Aetna
National Accounts CRT
P.O. Box 14001
Lexington, KY 40512

Your request should include:

- Your name;
- Your member ID number (or date of birth) or other identifying information;
- The group's name (for example, if you are covered by your employer);
- Comments, documents, records and other information you want us to consider.

You may also ask us for documents that are relevant to the unfavorable decision for your review. These are free. Call Member Services to ask for them. The toll-free telephone number is listed on your member ID card.

In general, one level of internal appeal is available under health plans providing coverage for individuals, and two levels of internal appeal are available under plans covering employees of an

employer.

ONE LEVEL APPEAL PROCESS:

If your plan offers a single appeal and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 30 days after we receive your request. For post-service appeal requests, we will send you a decision within 60 days after we receive your request.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 72 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

TWO LEVEL APPEAL PROCESS:

If your plan provides for two appeals and your appeal is pre-service (this means you need approval for coverage before you receive medical care), we will send you a decision within 15 days after we receive your request.

For post-service appeal requests, we will send you a decision within 30 days after we receive your request. In either case, if you do not agree with the decision you have the right to file a second request for appeal. To do this, call or write to us within 60 days from the date that you receive the first appeal decision.

If your appeal is urgent (one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain), you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372.

The National Clinical Appeal Unit will document phone requests in writing. We will give you a decision within 36 hours after we receive your request for review. If your appeal is urgent, you may also request an expedited external review at the same time as the internal appeal.

After your appeal, if we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review by an independent third party, who will review our decision and make a final decision. Contact your employer or refer to your plan documents for additional instruction on external review.

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.

We Protect Your Privacy:

Protecting the privacy of member health information is a top priority. When contacting us about this Notice or for help with other questions, please be prepared to provide member name, member ID number, and date of birth.

Member Services: If you, your authorized representative or your health care providers need help with filing an appeal or complaint or would like additional information about this decision, call the toll-free Member Services number on the member's identification card.

We hope this information has answered your coverage questions. Member Services representatives are available to help health care professionals, members and their authorized representatives with any questions about eligibility, plan benefits, claims and coverage decisions. If you, your authorized representative or your health care providers of record have additional questions or would like to request copies of documents related to the coverage decision, call the toll-free Member Services number on your member ID card.

Sincerely,

A handwritten signature in black ink, appearing to read "Jordan Pritzker MD", with a stylized flourish at the end.

Jordan Pritzker MD
Medical Director

The physician involved in making this decision may also be reached at (888) 422-4817.

A copy of this letter is also being sent to:

TAMI AHMAD
TLC SURGICAL CENTER

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