

<i>SERFF Tracking Number:</i>	<i>AENX-125868884</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40643</i>
<i>Company Tracking Number:</i>	<i>AH AR0086801F01</i>		
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.005C Individual - Other</i>
<i>Product Name:</i>	<i>2008 Medical</i>		
<i>Project Name/Number:</i>	<i>2008 Medical/AH AR0086801F01</i>		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2008 Medical

TOI: H16I Individual Health - Major Medical

Sub-TOI: H16I.005C Individual - Other

Filing Type: Form

SERFF Tr Num: AENX-125868884 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40643

Co Tr Num: AH AR0086801F01

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI

Disposition Date: 10/23/2008

Date Submitted: 10/22/2008

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 Medical

Project Number: AH AR0086801F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/23/2008

State Status Changed: 10/23/2008

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

The purpose of this filing is to broaden the coverage of [E-visits and] Walk-in clinic to the out of network component of our preferred provider medical expense plans. Please note these enhanced feature (s) were previously approved by your Department for in network only. The goal now is to broaden the benefit and offer the same coverage both in and out of network, while still retaining the option of "No Coverage" for out of network.

Company and Contact

SERFF Tracking Number: AENX-125868884 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 40643
 Company Tracking Number: AH AR0086801F01
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005C Individual - Other
 Product Name: 2008 Medical
 Project Name/Number: 2008 Medical/AH AR0086801F01

Filing Contact Information

John Ciesielski, Product and Regulatory Affairs CiesielskiJW@Aetna.com

Manager

151 Farmington Avenue (860) 279-1282 [Phone]
 Hartford, CT 06156 (860) 952-2069[FAX]

Filing Company Information

Aetna Life Insurance Company
 151 Farmington Avenue
 Hartford, CT 06156
 (860) 273-7546 ext. [Phone]

CoCode: 60054
 Group Code: 1
 Group Name: Aetna
 FEIN Number: 06-6033492

State of Domicile: Connecticut
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	10/22/2008	23393630

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/23/2008	10/23/2008

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Disposition

Disposition Date: 10/23/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Individual Direct	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-96484-02	Policy/Cont Individual Direct ract/Fraternal Certificate	Initial		0	GR-96484-02.PDF

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Effective Date: This Amendment is effective on the later of:

[October XX, 20XX]

The date you become covered under this policy.

Amendment – [State]

This Amendment describes certain changes in your Policy, which applies to residents of the [State of XXXXX]. This Amendment changes your Policy as follows.

(A) The “Glossary” section of the Policy is hereby amended to add the following definitions:

E-visit

An **E-visit** is an online internet consultation between a **[preferred] [participating] physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet **E-visit** service vendor.

Walk-in Clinic

Walk-in Clinics are **[preferred] [participating]**, free-standing health care facilities. They are an alternative to a **physician’s** office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

(B) “Other Covered Medical Expenses” appearing in the section, “Covered Medical Expenses” of the Policy is amended to add the following language:

- Charges by **[preferred] [participating] physicians** for **E-visits**. Registration with an internet service vendor may be required. Information about **Preferred Providers** who conduct **E-visits** may be found in DocFind on www.Aetna.com or by calling the number on your **Member** identification card.
- Charges for **Walk-in Clinic** visits for services and supplies provided by **[preferred] [participating] Walk-in Clinics**.

(C) The Summary of Coverage is hereby amended to add the following under Physicians’ Services:

E-visit by a Non-Specialist

Preferred Care

[\$0-50 **copay** per visit for the first 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **copay** per visit, thereafter 70-100%]

Non-Preferred Care

[\$0-50 **deductible** per visit for the 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **deductible** per visit, thereafter 70-100%]

[Not Covered]

E-visit by a Specialist

Preferred Care

[\$0-50 **copay** per visit for the first 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **copay** per visit, thereafter 70-100%]

Non-Preferred Care

[\$0-50 **deductible** per visit for the first 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **deductible** per visit, thereafter 70-100%]

[Not Covered]

Walk-in Clinic Visit

Preferred Care

[\$0-50 **copay** per visit for the first 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **copay** per visit, thereafter 70-100%]

Non-Preferred Care

[\$0-50 **deductible** per visit for the first 1-5 visits, thereafter 50-100%]

Or

[\$0-50 **deductible** per visit, thereafter 70-100%]

[Not Covered]



Ronald A. Williams
Chairman, Chief Executive Officer, and President

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	10/23/2008
Comments:				
Attachments:				
	AR - READABILITY CERTIFICATION.PDF			
	AR - NAIC TRANSMITTAL DOC.PDF			
	AR - NAIC FORM FILING ATTACHMENT.PDF			
Bypassed -Name:	Application	Review Status:	Approved-Closed	10/23/2008
Bypass Reason:	not applicable			
Comments:				
Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	10/23/2008
Bypass Reason:	not applicable			
Comments:				
Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	10/23/2008
Bypass Reason:	not applicable			
Comments:				

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Aetna Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GR-96484-02	0

Signed: _____

Name:

Title:

Date: _____

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT		001	60054	06-6033492	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	AH AR0086801F01
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7. <input type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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8. Market	Group	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise
		<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H16I Individual Health - Major Medical
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10. Product Coding Matrix Filing Code	H16I.005C Individual - Other
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11. Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	
15.	Filing Description:	
	The purpose of this filing is to broaden the coverage of [E-visits and] Walk-in clinic to the out of network component of our preferred provider medical expense plans. Please note these enhanced feature (s) were previously approved by your Department for in network only. The goal now is to broaden the benefit and offer the same coverage both in and out of network, while still retaining the option of "No Coverage" for out of network.	

16.	Certification (If required)	
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u> .		
Print Name <u>John Ciesielski</u> Title <u>Product and Regulatory Affairs Manager</u>		
Signature _____ Date _____		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	AH AR0086801F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Individual Direct	GR-96484-02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	