

SERFF Tracking Number: AENX-G126823669 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 46880
Company Tracking Number: AR034150100003
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & S
Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & SRC Conversion)/AR034150100003

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & S SERFF Tr Num: AENX-G126823669 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 46880

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: AR034150100003 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 10/07/2010

Date Submitted: 09/23/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & SRC Conversion)

Status of Filing in Domicile:

Project Number: AR034150100003

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/07/2010

Explanation for Other Group Market Type:

State Status Changed: 10/07/2010

Deemer Date:

Created By: SPI AetnaSPI

Submitted By: SPI AetnaSPI

Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms, Non-Grandfathered Immed Mkt Reforms

Filing Description:

Grandfathered and Non-Grandfathered, immediate market reformed.

The purpose of this filing submission is to bring Aetna's health plans into compliance with the Health Care Insurance Reform requirements that will become effective on September 23, 2010, as the result of the Federal Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act approved by Congress.

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Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Approvals Manager
 151 Farmington Avenue
 Mail Stop RW61
 Hartford, CT 06156
 CiesielskiJW@Aetna.com
 860-279-1282 [Phone]
 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: \$150.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$150.00	09/23/2010	39809558

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/07/2010	10/07/2010

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Disposition

Disposition Date: 10/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	HCR Conversion CovLTR	Approved-Closed	Yes
Supporting Document	EOV GR-IVLAppealsER-Pol 01, EOV GR-96692-HCR 01, EOV GR-96692SRC-HCR 01	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Appeals & ER Amend	Approved-Closed	Yes
Form	Policy Amend	Approved-Closed	Yes
Form	HCR Amend	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/07/2010	GR- IVLAppeals ER-Pol 02	Policy/Cont ract/Fratern al	Policy/Cont Appeals & ER ract/Fratern Amend al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.300	AL GE AIVLAppeals ERPol V002.PDF
Approved- Closed 10/07/2010	GR-96692- HCR 01	Policy/Cont ract/Fratern al	Policy/Cont Policy Amend ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		55.600	AL GE AGR96692H CR V001.PDF
Approved- Closed 10/07/2010	GR- 96692SRC- HCR 01	Policy/Cont ract/Fratern al	Policy/Cont HCR Amend ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		55.900	AL GE AGR96692SR CHCR V001.PDF

Aetna Life Insurance Company
Hartford, Connecticut 06156

Amendment

[Policyholder]: Mr. John Doe]

[Policy No.]: XXXX]

Effective Date: This Policy Amendment is effective on [October 1, 2010] [the later of:
October 1, 2010; or
The date you become covered under the Policy].

[The policy noted above has been amended.] The following summarizes the changes in the policy and it is amended accordingly. This amendment is effective on the date(s) shown above.

The following Appeals Procedure [Exhaustion of Process,] [and External Review] provisions [are added to] [replace the same provisions appearing in] your Policy [or any amendment or rider issued to you]:

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- [Coverage determinations, including] plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.

[As to medical and **prescription drug** claims,] An **adverse benefit determination** also means the termination of a covered person's coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy.

Appeal: An [oral or] written request to **Aetna** to reconsider an **adverse benefit determination**.

[Complaint: Any [oral or] written expression of dissatisfaction about quality of care or the operation of the Plan.]

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) [assigned by the State Insurance Commissioner] [that is Federally approved] made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

[As to medical and **prescription drug** claims and **appeals** only,] **Aetna** will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations – Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. [As to medical and **prescription drug** claims only,] if **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 24 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 48 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

[As to medical and **prescription drug** claims only,] if you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

[Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **[network] provider** you must [call or] write Member Services within 30 calendar days of the incident. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.]

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level [or two levels (Level Two only applies to dental, vision and hearing claims)] of **appeal**. [As to medical and **prescription drug** claims only,] a **final adverse benefit determination** notice will also provide an option to request an **External Review**.

You have 180 calendar days with respect to Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **appeal**. Your **appeal** [may be submitted orally or] [must be submitted] in writing and must include:

- Your name.
- [The Policyholder's name.]
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

[Send your written **appeal** to Member Services at the address shown on your ID Card, or call in your **appeal** to Member Services using the telephone number shown on your ID Card.]

[Send your written **appeal** to the address shown on the notice of **adverse benefit determination**, or you may call in your **appeal** using the telephone number listed on the notice.]

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

[As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.]

Level One Appeal – Health Claims

A review of a [Level One] **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

[Level Two Appeal - Dental, Vision and Hearing Claims

A Level Two Appeal applies only to dental, vision and hearing claims. If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.]

[A review of a Level Two **appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.]

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 24 hours of receipt of the request for a Level Two **Appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.]

[Exhaustion of Process

You must exhaust the applicable Level One [and Level Two] processes of the Appeal Procedure before you:

- Contact the [insert state name] Department of Insurance to request an investigation of a [complaint or] **appeal**; or
- File a complaint or **appeal** with the [insert state name] Department of Insurance; or
- Establish any:
 - litigation;
 - arbitration; or
 - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.]

[As to medical and **prescription drug** claims only,] under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.]

Important Note:

[As to medical and **prescription drug** claims only,] If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above.

[External Review

[As to medical and **prescription drug** claims only,] you may receive an **adverse benefit determination** or **final adverse benefit determination** [because **Aetna** determines that:

- the care is not **necessary**;
- a service, supply or treatment is **experimental or investigational** in nature.]

In these situations, you may request an **External Review** if you or your provider disagrees with **Aetna's** decision.

To request an **External Review**, [any of] the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice [of the denial of a claim] by **Aetna**.
- [• Your claim was denied because **Aetna** determined that the care was not **necessary** or was **experimental or investigational**.]
- You qualify for a faster review as explained below.
- [• As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds [\$100-\$500].]

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to **Aetna** within 123 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice. You also must include a copy of the notice and all other pertinent information that supports your request.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster review is possible if your **physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- seriously jeopardize your life or health; or
- jeopardize your ability to regain maximum function; or
- if the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay**; or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.]

[Aetna will abide by the decision of the ERO, except where Aetna can show conflict of interest, bias or fraud.]

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to Aetna. Aetna is responsible for the cost of sending this information to the ERO and for the cost of the external review [except for dental, vision and hearing claims].

For more information about the Appeals Procedure or External Review processes, call the Member Services telephone number shown on your ID card.]

This amendment makes no other changes to the Policy.



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

Aetna Life Insurance Company
(A Stock Company)

[Amendment: XXXX]
[Issue Date: October 1, 20XX]

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

[Policyholder: John Doe]

[Policy No.: 123456]

Effective Date: This Policy Amendment is effective on [October 1, 2010]
[the later of:

October 1, 2010; or

The date you become covered under the Policy.]

[The Policy as noted above has been changed.] This amendment is effective on the date(s) shown above.

This amendment changes the Policy as follows:

1. Any dollar overall plan Lifetime Maximum Benefit provision in your Policy no longer applies. All references to this maximum that may appear in your Policy or any amendment or rider issued to you are removed.
2. The eligibility rules for dependent children in your Policy have been amended. Dependent children will now be eligible for [**prescription drug** and] medical expense coverage if they are under [26-30] years of age. Any rule that they be a full-time student, unmarried or solely dependent upon you for support will not apply.

If you have a child that can now be enrolled under these new rules, please contact **Member Services** for details.

-
- [3. The following *[Wellness] Benefits* are added to the medical expense coverage section of your Policy and are now covered medical expenses. They are payable at 100% per visit and without cost-sharing requirements such as **coinsurance**, **deductibles** and dollar maximum benefits:

[Wellness] Benefits

This [Wellness] Benefit describes the covered medical expenses for services and supplies provided when you are well.

Routine Physical Exams

Covered medical expenses include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- [• Radiological services; x-rays; lab; and other tests given in connection with the exam;
- Routine vision and hearing screenings;
- Immunizations for infectious diseases and the materials to administer immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.]

Covered medical expenses for children from birth through age 18 also include:

- [• An initial hospital check up and well child visits. These must be in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians. This includes routine oral; vision; and hearing screenings.]

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Services which are for diagnosis or treatment of a suspected or identified illness or injury.
- Exams given during your stay for medical care.
- Services not given by a **physician** or under his or her direction.
- Psychiatric, psychological, personality or emotional testing or exams.]

[Routine Cancer Screenings]

Covered medical expenses include charges incurred for routine cancer screening as follows:

- [• [1-4] mammogram every [6-12] months for covered females age [30-40] and over;
- [1-4] Pap smears every [6-12] months;
- [1-4] gynecological exams every [6-12] months (this includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer);
- [1-4] fecal occult blood test every [6-12] months; and
- [1-4] digital rectal exam and [1-4] prostate specific antigen (PSA) test every [6-12] months for covered males age [30-40] and older.]

The following tests are covered medical expenses if you are age [40-50] and older when recommended by your **physician**:

- [• [1-4] sigmoidoscopy every [1-5] years for persons at average risk; *or*
- [1-4] double contrast barium enema (DCBE) every [1-5] years for persons at average risk; *or*
- [1-4] colonoscopy every [1-10] years for persons at average risk for colorectal cancer.]

These benefits are subject to age, family history and frequency guidelines as shown above. The guidelines will be determined by applying the more generous rules, as they apply to you, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
- the state laws and regulations that govern the Policy.

Any exclusions in your Policy for these types of *[Wellness] Benefits* no longer apply and are deleted.]

- [4.] Any [monthly; per visit; per day;] lifetime [and calendar year] dollar maximum benefit that applies to an "**Essential Service**" (as defined by the Federal Department of Health and Human Services), no longer applies.

If your Plan includes coverage for the following **Essential Services** and such services include these dollar maximums, then the maximums are removed from your Policy and any amendments or riders that have been issued to you:

- [• Allergy Testing and Treatment (includes allergy injections);
- Administration of Anesthesia;
- **Birthing Center** Services;
- Emergency Medical Services (includes **Physician**, Emergency Room and Ambulance Services);
- Home Health Care (Outpatient);
- **Hospice Care**;
- **Hospital** Expenses incurred while confined as an inpatient;
- Immunizations (not part of a physical exam);
- Oral and Maxillofacial Treatment-Facility Expenses (Mouth, Jaws and Teeth);
- Outpatient Diagnostic Lab and X-ray Services (at a hospital or other facility);
- Outpatient Surgery (performed in a **Physician's** Office, at a Hospital Outpatient Facility or a **Surgery Center** or Facility);
- Outpatient Therapy (Chemotherapy, Infusion and Radiation);
- **Physician** Office Visits (including E-Visit consultations);
- Pregnancy and Newborn Child Care;
- **Prescription Drugs**;
- Private Duty Nursing (Inpatient and Outpatient);
- Prosthetic Devices;
- Short Term Outpatient Rehabilitation Therapies (Cardiac, Cognitive, Occupational, Physical, Pulmonary, Speech);
- **Skilled Nursing Facility Services** (Convalescent Facility);
- Skilled Nursing Care (Inpatient and Outpatient);
- Transplant Services Facility and Non-Facility Expenses;
- Treatment of [**Mental Disorders**] (Inpatient and Outpatient);
- Treatment of [**Substance Abuse**] (Inpatient and Outpatient);
- Urgent Care; and
- Walk-In Clinic Non-Emergency Visit.]

Essential Services will continue to be subject to any **coinsurance**, **deductibles**, [other types of maximums (e.g., day and visit maximums),] and any exclusions and limitations that apply to these types of covered medical expenses in your Policy.

-
- [5. The following "**Essential Services** Calendar Year Maximum" has been added to your Policy:

Essential Services Calendar Year Maximum Benefit

The most the plan will pay for medical [and **prescription drug**] covered expenses incurred by any one covered person in a calendar year for all **Essential Services** combined is [\$750,000-10,000,000].]

This amendment makes no other changes to your Policy.



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

[Amendment: XXXX]

[Issue Date: October 1, 20XX]

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

[Policyholder: John Doe]

[Policy No.: 123456]

Effective Date: This Policy Amendment is effective on [October 1, 2010]
[the later of:

October 1, 2010; or

The date you become covered under the Policy.]

[The Policy as noted above has been changed.] This amendment is effective on the dates shown above.

This amendment changes the Policy as follows:

1. Any dollar ["Overall Maximums in a Calendar Year" and] "Supplemental Medical Lifetime Maximum" in your Policy no longer applies. All references to these maximums that appear in your [Summary of Coverage,] Policy or any amendments or riders that have been issued to you, are removed.
2. The eligibility rules for dependent children in your Policy have been changed. Dependent children will now be eligible for prescription drug and medical expense coverage if they are under [26-30] years of age. Any rule that they be a full-time student, unmarried or solely dependent upon you for support will not apply.

If you have a child that can now be enrolled under these new rules, please contact **Member Services** for details.

-
- [3. The following "[Wellness] Benefits" replaces the "Routine Preventive Care Expenses" appearing in your Policy. Any references to "Preventive Care Benefits" in your Policy are hereby deleted.

[Wellness] Benefits will be payable at 100% per visit and without cost-sharing requirements such as **coinsurance**, **deductibles** and dollar maximum benefits:

[Wellness] Benefits

This [Wellness] Benefit describes the covered medical expenses for services and supplies provided when you are well.

Routine Physical Exams

Covered medical expenses include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- [• Radiological services; x-rays; lab; and other tests given in connection with the exam;
- Routine vision and hearing screenings;
- Immunizations for infectious diseases and the materials to administer immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.]

Covered medical expenses for children from birth through age 18 also include:

- [• An initial hospital check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric **Physicians**, including routine oral; vision; and hearing screenings.]

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Services which are for diagnosis or treatment of a suspected or identified illness or injury.
- Exams given during your stay for medical care.
- Services not given by a **physician** or under his or her direction.
- Psychiatric, psychological, personality or emotional testing or exams.]

[Routine Cancer Screenings]

Covered medical expenses include charges incurred for routine cancer screening as follows:

- [• [1-4] mammogram every [6-12] months for covered females age [30-40] and over;
- [1-4] Pap smears every [6-12] months;
- [1-4] gynecological exams every [6-12] months (this includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer);
- [1-4] fecal occult blood test every [6-12] months; and
- [1-4] digital rectal exam and [1-4] prostate specific antigen (PSA) test every [6-12] months for covered males age [30-40] and older.]

The following tests are covered medical expenses if you are age [40-50] and older when recommended by your **physician**:

- [• [1-4] sigmoidoscopy every [1-5] years for persons at average risk; *or*
- [1-4] double contrast barium enema (DCBE) every [1-5] years for persons at average risk; *or*
- [1-4] colonoscopy every [1-10] years for persons at average risk for colorectal cancer.]

These benefits are subject to age, family history and frequency guidelines as shown above. The guidelines will be determined by applying the more generous rules, as they apply to you, as set forth in:

- the most recently published preventive health care guidelines as required by the Federal Department of Health and Human Services; or
- the state laws and regulations that govern the Policy.

Any exclusions in your Policy for these types of *[Wellness] Benefits* no longer apply and are deleted.]

- [4.] Any [monthly; per visit; per day;] lifetime [and calendar year] dollar maximum benefit that applies to an "**Essential Service**" (as defined by the Federal Department of Health and Human Services), no longer applies.

If your Plan includes coverage for the following **Essential Services** and such services include these dollar maximums, then the maximums are removed from your Policy and any amendments or riders that have been issued to you:

- [• Allergy Testing and Treatment (includes allergy injections);
- Administration of Anesthesia;
- **Birth Centers**;
- Emergency Medical Services (includes **Physician**, Emergency Room and Ambulance Services);
- Home Health Care (Outpatient);
- **Hospice Care**;
- **Hospital** Expenses incurred while confined as an inpatient;
- Immunizations (not part of a physical exam);
- Oral and Maxillofacial Treatment-Facility Expenses (Mouth, Jaws and Teeth);
- Outpatient Diagnostic Lab and X-ray Services (at a hospital or other facility);
- Outpatient Surgery (performed in a **Physician's** Office, at a Hospital Outpatient Facility or a **Surgery Center** or Facility);
- Outpatient Therapy (Chemotherapy, Infusion and Radiation);
- **Physician** Office Visits (including E-Visit consultations);
- Pregnancy and Newborn Child Care;
- **Prescription Drugs**;
- Private Duty Nursing (Inpatient and Outpatient);
- Prosthetic Devices;
- Short Term Outpatient Rehabilitation Therapies (Cardiac, Cognitive, Occupational, Physical, Pulmonary, Speech);
- **Skilled Nursing Facility Services** (Convalescent Facility);
- Skilled Nursing Care (Inpatient and Outpatient);
- Transplant Services Facility and Non-Facility Expenses;
- Treatment of [**Mental Disorders**] (Inpatient and Outpatient);
- Treatment of [**Substance Abuse**] (Inpatient and Outpatient);
- Urgent Care; and
- Walk-In Clinic Non-Emergency Visit.]

Essential Services will continue to be subject to any **coinsurance**; **deductibles**; [other types of maximums (e.g., day and visit maximums;)] and any exclusions and limitations that apply to these types of covered medical expenses in your Policy.

[5. The following "**Essential Services** Calendar Year Maximum" has been added to your Policy:

Essential Services Calendar Year Maximum Benefit

The most the plan will pay for medical and **prescription drug** covered medical expenses incurred by any one covered person in a calendar year for all **Essential Services** combined is [\$750,000-\$10,000,000].]

This amendment makes no other changes to your Policy.



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

[Amendment: XXXX]

[Issue Date: October 1, 20XX]

SERFF Tracking Number: AENX-G126823669 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46880
 Company Tracking Number: AR034150100003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & S
 Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & SRC Conversion)/AR034150100003

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/07/2010
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	10/07/2010
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	10/07/2010
Comments:		
Attachment:		
ar PPAC uniform compliance summary.PDF		

	Item Status:	Status Date:
Satisfied - Item: HCR Conversion CovLTR	Approved-Closed	10/07/2010
Comments:		
Attachment:		
ar HCR Conversion CovLTR.PDF		

	Item Status:	Status Date:
Satisfied - Item: EOVS GR-IVLAppealsER-Pol 01, EOVS GR-96692-HCR 01, EOVS GR-	Approved-Closed	10/07/2010

SERFF Tracking Number: AENX-G126823669 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 46880
Company Tracking Number: AR034150100003
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & S
Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Aetna & SRC Conversion)/AR034150100003
96692SRC-HCR 01

Comments:

Attachments:

AL GE EAIVLAppealsERP01 V001.PDF
AL GE EAGR96692HCR V001.PDF
AL GE EAGR96692SRCHCR V001.PDF

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	10/07/2010

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOCUMENT.PDF
AR - NAIC FORM FILING ATTACHMENT.PDF

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-IVLAppealsER-Pol 02	51.3
GR-96692-HCR 01	55.6
GR-96692SRC-HCR 01	55.9

Signed: John W Ciesielski

Name: John W Ciesielski

Title: Senior Consultant

Date: September 23, 2010

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

INDIVIDUAL HEALTH BENEFIT PLANS (Complete [SECTION A](#) only)

SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Aetna Life Insurance Company	001-60054	AENX-G126823669	GR-30608-BD-Rev GR-65165 Rev and GR-30608 GR-30140A GR-96332-AR 01-06	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H06 Health - Conversion	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: Variability of current approved forms support or do not include pre-existing condition exclusion for enrollees under age 19			If no , please explain.
	Page Number:			
H06 Health - Conversion	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Explanation:			If no , please explain.
	Page Number: GR-96692-HCR 01			
H06 Health - Conversion	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	Explanation:		If no , please explain.	If no , please explain.
	Page Number: GR-96692-HCR 01			
H06 Health - Conversion	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: Current approved forms do not include a rescission provision.		If no , please explain.	If no , please explain.
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H06 Health - Conversion	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: GR-96692-HCR 01			
H06 Health - Conversion	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: GR-96692-HCR 01			
H06 Health - Conversion	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: GR-IVLAppealsER-Pol 02			
H06 Health - Conversion	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Current approved forms support this requirement.			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H06 Health - Conversion	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Variability of current approved forms support this provider designation.			
	Page Number:			
H06 Health - Conversion	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Variability of current approved forms support direct access for OB/GYNs.			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services Explanation: Page Number:	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊ Explanation: Page Number:	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes • <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number:	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

- For plan years beginning before January 1, 2010, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B ñ Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.



John W. Ciesielski
Product & Regulatory Affairs
Law and Regulatory Affairs
151 Farmington Ave, RW61
Hartford, CT 06156
(845) 279-1282
Fax: (860) 952-2065
Email: Ciesielskijw@aetna.com

September 23, 2010

Insurance Commissioner Julie Benafield Bowman
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Subject: **Aetna Life Insurance Company, NAIC No. 001-60054**
Accident & Health Insurance Conversion Coverage
**Health Care Insurance Reform Provisions (Effective September 23, 2010) -
Grandfathered & Non-Grandfathered Plans**
- Appeals Policy Amendment: GR-IVLAppealsER-Pol 02
- Policy Amendment: GR-96692-HCR 01
- Policy Amendment: GR-96692SRC-HCR 01

Dear Commissioner:

The conversion Policy Amendment forms listed above are being submitted for your Department's approval on a general use basis. The forms are new and do not replace any previously filed forms. They are in final form rather than being drafts or proofs.

All of the forms attached to this filing submission will be used for both "grandfathered" and "non-grandfathered" health plans.

PPACA Uniform Compliance Summary

As required by your state, please find the completed PPACA Uniform Compliance Summaries. The *Section A Individual Health Benefit Plan* portion of the Summary has been completed for this submission.

The purpose of this filing submission is to bring Aetna's conversion health plans into compliance with the Health Care Insurance Reform (HCR) requirements that will become effective on September 23, 2010, as the result of the Federal Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act approved by Congress. The HCR laws include the following changes:

- *Preexisting Conditions* - Elimination of the Preexisting Conditions Exclusion for Covered Persons less than 19 years of age.
- *Overall Plan Dollar Limits* - Elimination of overall plan annual and lifetime dollar limits.

- *Dollar Limits on Essential Services* - Elimination of calendar year and lifetime dollar limits that apply individually to “Essential Services”. The addition of an Essential Services Calendar Year Maximum that applies to all combined Essential Services.
- *Prohibition of Rescissions* (except for fraud or intentional misrepresentation of material fact). The requirement includes a 30 day advance written notice prior to the date of the rescission.
- *Preventive Services* - Requires coverage of preventive health services and prohibits the imposition of cost-sharing for specified preventive services.
- *Dependents Coverage to Age 26* - Extension of Dependent Coverage for Children up to Age 26 (applies to medical and prescription drug coverage) without dependency requirements such as being a full-time student, unmarried or solely dependent upon the parents for support.
- *Appeals/External Review Process* - Requires establishment of an internal claims appeal process and external review process.
- *Emergency Services* - Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.
- *Access to Pediatricians* - If designation of a PCP is required for a child, the child must be permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network.
- *Access to OB/GYN's* - Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who are licensed to provide such services.
- *Selection of PCP* - Requires plans, which allow or require the choice of a primary care physician, to allow a member to choose from any participating primary care physician that is available to accept patients.

Aetna has reviewed the below mentioned Aetna Conversion Policy forms with regard to the September 23, 2010 HCR changes and has determined that they do not support the following:

- *Overall Plan Dollar Limits* - Elimination of overall plan annual and lifetime dollar limits.
- *Dollar Limits on Essential Services* - Elimination of calendar year and lifetime dollar limits that apply individually to “Essential Services”. The addition of an Essential Services Calendar Year Maximum that applies to all combined Essential Services.
- *Preventive Services* - Requires coverage of preventive health services and prohibits the imposition of cost-sharing for specified preventive services.
- *Dependents Coverage to Age 26* - Extension of Dependent Coverage for Children up to Age 26 (applies to medical and prescription drug coverage) without dependency requirements such as being a full-time student, unmarried or solely dependent upon the parents for support.
- *Appeals/External Review Process* - Requires establishment of an internal claims appeal process and external review process. The external review process must mirror the NAIC model.

As to the remaining health care reform changes (as listed above), Aetna has determined that our claim practices and current approved forms either already comply with the mandates or contain sufficient variability to accommodate the changes and, therefore, a forms filing is not required.

Aetna has reviewed the below mentioned Aetna SRC Conversion Policy forms with regard to the September 23, 2010 HCR changes and has determined that they do not support the following:

- *Overall Plan Dollar Limits* - Elimination of overall plan annual and lifetime dollar limits.

- *Dollar Limits on Essential Services* - Elimination of calendar year and lifetime dollar limits that apply individually to “Essential Services”. The addition of an Essential Services Calendar Year Maximum that applies to all combined Essential Services.
- *Preventive Services* - Requires coverage of preventive health services and prohibits the imposition of cost-sharing for specified preventive services.
- *Dependents Coverage to Age 26* - Extension of Dependent Coverage for Children up to Age 26 (applies to medical and prescription drug coverage) without dependency requirements such as being a full-time student, unmarried or solely dependent upon the parents for support.
- *Appeals/External Review Process* - Requires establishment of an internal claims appeal process and external review process. The external review process must mirror the NAIC model.

As to the remaining health care reform changes (as listed above), Aetna has determined that our claim practices and current approved forms either already comply with the mandates or contain sufficient variability to accommodate the changes and, therefore, a forms filing is not required.]

Aetna Conversion Policies

We intend to use the policy amendment forms GR-96692-HCR 01 and GR-IVLAppeals-Pol 01, with the following Basic and Comprehensive Medical Conversion Policy Forms:

- GR-30140A (Basic);
- GR-61565 (Basic);
- GR-61565-Rev (Basic);
- GR-30608 (Comp);
- GR-30608-BD (Comp); and
- GR-30608–BD-Rev (Comp).

The Appeals Policy Amendment form GR-IndivAppeals-Pol 02 will be used with all of the Aetna Conversion policy forms listed above. *Although the appeals and external review reform applies only to non-grandfathered plans, Aetna is applying this requirement to both grandfathered and non-grandfathered plans to establish consistency for all health plans.*

Aetna Limited Medical Conversion Policies

We intend to use the policy amendment forms GR-96692SRC-HCR 01 and GR-IVLAppeals-Pol 02 with the Limited Major Medical Conversion Policy Form GR-96332. This policy form is issued to individuals who were covered under an Aetna limited medical benefit group plan and elected conversion in accordance with the conversion privilege of the group policy. *Although the appeals and external review reform applies only to non-grandfathered plans, Aetna is applying this requirement to both grandfathered and non-grandfathered plans to establish consistency for all health plans.*

It is important to note that while Aetna is filing an amendment for this conversion policy, the limited conversion health plan supported by this policy may be subject to the "waiver program" for limited or mini-med plans that will be developed by HHS. Aetna will be actively pursuing a waiver of the HCR requirements for this conversion health plan. Once the HHS waiver program is in place, and Aetna has applied for and is accepted under the waiver program, then Aetna will not use this amendment for this policy form. The amendment form is being filed only for use in the event that Aetna's application is not approved.]

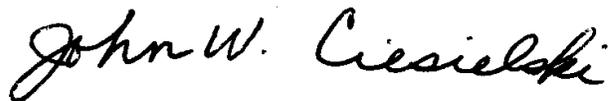
All of the amendment forms submitted with this filing will be issued to existing and new policyholders to amend their forms in response to health care reform.

Variability, as indicated by bracketed material on the forms, is required so that only the appropriate language may be reflected on the forms. Upon issuance of these documents, the placement of textual material may vary to avoid gaps that would otherwise be created by the deletion of bracketed material. Provisions may appear in sequence other than that shown. Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the policy, may vary as the sense demands. Detailed Explanations of Variability for the forms have been included.

We request approval of the enclosed forms and any attachments.

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the above mailing address, telephone number or e-mail address.

Sincerely,

A handwritten signature in black ink that reads "John W. Ciesielski". The signature is written in a cursive style with a large, sweeping initial "J".

John W Ciesielski
Manager
Product & Regulatory Affairs

Enclosure(s)

Aetna Life Insurance Company

Appeals & External Review

Explanation of Variable Material Policy Amendment Form GR-IVLAppealsER-Pol 01

General Comments

1. Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits.
2. *Although the appeals and external review reform applies only to non-grandfathered plans, Aetna is applying this requirement to both grandfathered and non-grandfathered plans to establish consistency for all health plans.*
3. This amendment is intended to be issued to new and existing policyholders.
4. Upon issue, this amendment form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder, state mandates and this explanation of variability.
5. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
6. Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
7. The page numbers are variable so that they may be omitted or to allow that the placement of material be changed in order to avoid gaps and to allow the contractual documents to be system produced.
8. The bracketed designation [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state mandates. If the page has been modified, then the initial abbreviation of your state may be added to identify that the form is state specific. For example, for the State of Connecticut, a "CT" will print.
9. The name and signature of the Aetna officer at the end of the amendment will change to the most current information.
10. If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a Policyholder's specific documents.

Policy Amendment Form GR-IVLAppealsER-Pol 01

11. The "Policyholder Name" and "Policy Number" field is for policyholder-specific information and may not print upon issue. The bracketed phrase "[The policy noted above has been changed.]" will print if the policy number is included on the amendment upon issue.
12. The lead-in paragraphs will be revised to accurately state the manner in which the provisions will amend the insurance forms of a policyholder. The references to Exhaustion of Process and External Review will print if applicable under a policyholder's plan.
13. *Definition - Appeal:* An appeal must be requested in writing but may also be requested orally.
14. *Definition - Complaint:*
 - a. The definition of "complaint" may or may not be incorporated into the provision, depending on whether or not a complaint component is included in a policyholder's plan.
 - b. Any complaint must be expressed in writing but may also be permitted orally.

Explanation of Variable Material
Policy Amendment Form GR-IVLAppealsER-Pol 01

15. *Claim Determinations - Health Coverage:*
 - a. Written notice of an adverse benefit determination may be limited to medical and prescription drug coverage or may be expanded to include other health coverage such as standalone dental, vision and hearing.
 - b. Concurrent Care Claim Reduction or Termination-This continuation provision may be limited to medical and prescription drug coverage or may be expanded to include other health coverage such as standalone dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
16. *Complaints:*
 - a. This provision may be included in a policyholder's plan.
 - b. The term "network" may be revised to "in-network", "participating", "preferred" or some other term of similar meaning as used within a policyholder's forms.
 - c. The complaint must be expressed in writing but may also be permitted orally.
17. *Appeals of Adverse Benefit Determinations:*
 - a. The references to [one level] and [or two levels] will print in accordance with a policyholder's plan.
 - b. The external review process may be limited to medical and prescription drug coverage or may be expanded to include other health coverage such as dental, vision and hearing.
 - c. The plan may require that the appeal be made in writing.
 - d. The Policyholder's name may be required information for the appeal.
 - e. The appeal process may allow that a member submit a written or oral appeal. When the plan requires a written appeal, the references to "calling in an appeal" will be omitted. The address may appear on the back of the ID card or in the notice of adverse benefit determination. Only one of these two options will print.
 - f. Evidence/Testimony-This provision is bracketed because it will be omitted if the policyholder's plan does not include medical or prescription drug coverage. For medical and prescription drug coverage, it will be included as required and in accordance with the final HHS regulation. It may be limited to medical and prescription drug coverage or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
18. *Level One Appeal - Health Claims:*
 - a. The reference to Level One will be omitted if there is only one level of appeal.
 - b. If the Health Appeals Procedure includes only One Level, then the following appeal time periods will apply:
 - Urgent Care Claims will be made in 72 hours;
 - Pre-Service Claims will be made in 30 calendar days; and
 - Post-Service Claims will be made in 60 calendar days.
19. *Level Two Appeal - Health Claims:* This Level Two health appeal process description will print if included as part of the policyholder's plan.
20. *Exhaustion of Process:*
 - a. This provision is subject to inclusion or omission based upon a policyholder's plan.
 - b. The reference to [Level One and Level Two] will be changed to reflect the policyholder's plan.
 - c. The reference to [complaint or] will be included when the Appeals Procedure includes the Complaint provision.

Explanation of Variable Material
Policy Amendment Form GR-IVLAppealsER-Pol 01

21. *External Review:*
- a. This provision may be limited to medical and prescription drug coverage or may be expanded to include other health coverage such as standalone dental, vision and hearing. The entire provision may be omitted if a policyholder's plan only includes standalone dental, vision or hearing coverage.
 - b. The bulleted item concerning the "cost of the service, supply or treatment" will be omitted if prohibited under the HHS appeal regulation. If the provision is applicable, the dollar amount will vary within the stated range.
 - c. Aetna may incur the entire cost of the External Review (*see the second to the last paragraph*).

Aetna Life Insurance Company

Explanation of Variable Material Conversion Policy Amendment Form GR-96692-HCR 01

General Comments

1. *This amendment applies to both grandfathered and non-grandfathered plans.*
2. Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits.
3. This amendment is intended to be issued to existing policyholders but may also be issued to new policyholders. It will be used to temporarily revise a policyholder's forms to describe Health Care Reform changes to a policyholder's plan of benefits.
4. Upon issue, this amendment form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder, state mandates and this explanation of variability.
5. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
6. The page numbers are variable so that they may be omitted or adjusted as necessary due to the deletion of variable text upon issue.
7. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" as used in a Policyholder's forms.
8. The item number designations (ex. [3.]) will change when text is omitted from the amendment.
9. The bracketed designations [Conversion-Aetna] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state mandates. If the page has been modified, then the initial abbreviation of your state may be added to identify that the form is state specific. For example, for the State of Connecticut, a "CT" will print.
10. The name and signature of the Aetna officer at the end of the amendment will change to the most current information.
11. If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a Policyholder's specific documents.

Conversion Policy Amendment Form GR-96692-HCR 01

12. The "Policyholder Name" and "Policy Number" field is for policyholder-specific information and may not print upon issue. The bracketed phrase "The policy noted above has been changed." will print if the policy number is included on the amendment upon issue.
13. *Item 1: This item applies to both grandfathered and non-grandfathered plans.*
14. *Item 2:*
 - a. *This item applies to both grandfathered and non-grandfathered plans.*
 - b. The reference to "prescription drugs" will print if such expenses are covered under the plan.
 - c. The age will vary within the stated range.

Explanation of Variable Material
Conversion Policy Amendment Form GR-96692-HCR 01

15. *Item 3:*
- a. ***This item applies to non-grandfathered plans.***
 - b. The term "Wellness" may be revised to "Preventive Care".
 - c. *Routine Physicals Exams*-The lists of services for adults and children are bracketed to allow Aetna to publish the final lists of services, as defined by the Federal Department of Health and Human Services (HHS), when this form is issued to policyholders.
 - d. *Routine Cancer Screenings*: The lists of services are bracketed to allow Aetna to publish the final lists of services and frequencies, as defined by HHS, when this form is issued to policyholders.
16. *Item 4:*
- a. ***This item applies to both grandfathered and non-grandfathered plans.***
 - b. The bracketed maximums "monthly; per visit; per day;" will print if the final regulation, as issued by HHS, does not permit such dollar maximums. This list of maximums may be expanded to include additional types of maximums that may be prohibited under HHS.
 - c. ***The bracketed reference to "calendar year" applies to non-grandfathered plans only.***
 - d. The bracketed list of services is variable to allow Aetna to publish the final list of "Essential Services", as defined by HHS, when this form is issued to policyholders.
 - e. The list may vary in accordance with the types of maximums included in a policyholder's plan that apply to these services. For example, if the plan does not apply a dollar maximum to "Emergency Medical Services", then Emergency Medical Services will not be listed. The list will also vary with the types of services that are covered under a policyholder's plan.
 - f. The term "Mental Disorders" will be revised to the appropriate term as used in a policyholder's forms (ex. Mental Health, Mental Illness, etc).
 - g. The term "Substance Abuse" will be revised to the appropriate term as used in a policyholder's forms (ex. Alcoholism and Drug Abuse or Chemical Dependency).
 - h. The reference to [other types of maximums (e.g., day and visit maximums);] will be omitted if not included in the plan.
17. *Item 5:*
- a. ***This item applies to both grandfathered and non-grandfathered plans. However, it is bracketed because a plan design may not include this maximum.***
 - b. The reference to "prescription drugs" will print if such expenses are covered under the plan.
 - c. The dollar amount will vary within the stated range in accordance with HHS regulation.

Aetna Life Insurance Company

Explanation of Variable Material SRC Conversion Policy Amendment Form: GR-96692SRC-HCR 01

General Comments

1. ***This amendment applies to both grandfathered and non-grandfathered plans.***
2. Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits.
3. This amendment is intended to be issued to existing customers but may also be issued to new customers. It will be used to temporarily revise a policyholder's forms to describe Health Care Reform changes to a policyholder's plan of benefits.
4. Upon issue, this amendment form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder, state mandates and this explanation of variability.
5. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
6. The page numbers are variable so that they may be omitted or adjusted as necessary due to the deletion of variable text upon issue.
7. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" as used in a Policyholder's forms.
8. The item number designations (ex. [3.]) will change when text is omitted from the amendment.
9. The bracketed designations [Conversion-SRC] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state mandates. If the page has been modified, then the initial abbreviation of your state may be added to identify that the form is state specific. For example, for the State of Connecticut, a "CT" will print.
10. The name and signature of the Aetna officer at the end of the amendment will change to the most current information.
11. If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a Policyholder's specific documents.

SRC Conversion Policy Amendment Form: GR-96692SRC-HCR 01

12. The "Policyholder Name" and "Policy Number" field is for policyholder-specific information and may not print upon issue. The bracketed phrase "The policy noted above has been changed." will print if the policy number is included on the amendment upon issue.
13. *Item 1:*
 - a. ***This item will print for both grandfathered and non-grandfathered plans.***
 - b. *The reference to "calendar year" will print for non-grandfathered plans only.*
 - c. The reference to "Summary of Coverage" may be changed to "Schedule of Benefits" or some other term of similar meaning.
14. *Item 2:*
 - a. ***This item will print for both grandfathered and non-grandfathered plans.***
 - b. The age will vary within the stated range.

Explanation of Variable Material
SRC Conversion Policy Amendment Form: GR-96692SRC-HCR 01

15. *Item 3:*
- a. ***This item will print for non-grandfathered plans only.***
 - b. The term "Wellness" may be changed to "Preventive Care".
 - c. *Routine Physicals Exams*-The lists of services for adults and children are bracketed to allow Aetna to publish the final lists of services, as defined by the Federal Department of Health and Human Services (HHS), when this form is issued to policyholders.
 - d. *Routine Cancer Screenings*: The lists of services are bracketed to allow Aetna to publish the final lists of services and frequencies, as defined by HHS, when this form is issued to policyholders.
16. *Item 4:*
- a. ***This item will print for both grandfathered and non-grandfathered plans.***
 - b. The bracketed maximums "monthly, per visit, per day" will print if the final regulation, as issued by HHS, does not permit such dollar maximums. This list of maximums may be expanded to include additional types of maximums that may be prohibited under HHS. *The reference to "calendar year" will print for non-grandfathered plans only.*
 - c. The bracketed list of services is variable to allow Aetna to publish the final list of "Essential Services", as defined by HHS, when this form is issued to policyholders.
 - d. The list may vary in accordance with the types of maximums included in a policyholder's plan that apply to these services. For example, if the plan does not apply a dollar maximum to "Emergency Medical Services", then Emergency Medical Services will not be listed. The list will also vary with the types of services that are covered under a policyholder's plan.
 - e. The term "Mental Disorders" will be revised to the appropriate term as used in a policyholder's forms (ex. Mental Health, Mental Illness, etc).
 - f. The term "Substance Abuse" will be revised to the appropriate term as used in a policyholder's forms (ex. Alcoholism and Drug Abuse or Chemical Dependency).
 - g. The reference to "other types of maximums (e.g., day and visit maximums)" will be omitted based upon a policyholder's plan.
17. *Item 5:*
- a. ***This item applies to both grandfathered and non-grandfathered plans. However, it is bracketed because a plan design may not include this maximum.***
 - b. The dollar amount will vary within the stated range in accordance with HHS regulation.

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 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	AR034150100003
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7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise Group	<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: _____
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9. Type of Insurance	H16G Group Health - Major Medical
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10. Product Coding Matrix Filing Code	H16G.001C Any Size Group - 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:	
	Grandfathered and Non-Grandfathered, immediate market reformed. The purpose of this filing submission is to bring Aetna's health plans into compliance with the Health Care Insurance Reform requirements that will become effective on September 23, 2010, as the result of the Federal Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act approved by Congress.	

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>Manager</u> Product and Regulatory Approvals
Signature	<u>John W/ Ciesielski</u>	Date <u>September 23, 2010</u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	AR034150100003	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Appeals & ER Amend	GR-IVLAppealsER-Pol 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Policy Amend	GR-96692-HCR 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	HCR Amend	GR-96692SRC-HCR 01	<input checked="" 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 _____	