

SERFF Tracking Number: AENX-G126844617 State: Arkansas  
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46969  
 Company Tracking Number: AR034160100002  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005C Individual - Other  
 Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individua  
 Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Individual-Direct)/AR034160100002

## Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individua SERFF Tr Num: AENX-G126844617 State: Arkansas

TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 46969

Sub-TOI: H16I.005C Individual - Other Co Tr Num: AR034160100002 State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 10/11/2010  
 Date Submitted: 10/04/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individual-Direct) Status of Filing in Domicile:

Project Number: AR034160100002

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: 10/11/2010

Explanation for Other Group Market Type:

State Status Changed: 10/11/2010

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: \$20.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$20.00	10/04/2010	40220331
Aetna Life Insurance Company	\$50.00	10/08/2010	40470688
Aetna Life Insurance Company	\$30.00	10/11/2010	40568894

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/11/2010	10/11/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/11/2010	10/11/2010	SPI AetnaSPI	10/11/2010	10/11/2010
Pending Industry Response	Rosalind Minor	10/08/2010	10/08/2010	SPI AetnaSPI	10/08/2010	10/08/2010

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## **Disposition**

Disposition Date: 10/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-G126844617 State: Arkansas  
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 Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individua  
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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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	HCR Indiv Direct CovLTR	Approved-Closed	Yes
Supporting Document	EOV GR-IVLAppeals-Pol 02, EOV GR-11741-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	HCR Amend	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/11/2010

Submitted Date 10/11/2010

Respond By Date

Dear John Ciesielski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Appeals & ER Amend, GR-IVLAppealsER-Pol 02 (Form)
- HCR Amend, GR-11741-HCR 01 (Form)

Comment:

We still need an additional \$30.00 in filing fees. The fees are \$50.00 per form for a total of \$100.00 on this filing. So far, you have submitted a total of \$70.00.

Thank you.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 10/11/2010  
Submitted Date 10/11/2010

Dear Rosalind Minor,

### Comments:

Filing fees

### Response 1

Comments: Additional fee processed

### Related Objection 1

Applies To:

- Appeals & ER Amend, GR-IVLAppealsER-Pol 02 (Form)
- HCR Amend, GR-11741-HCR 01 (Form)

Comment:

We still need an additional \$30.00 in filing fees. The fees are \$50.00 per form for a total of \$100.00 on this filing. So far, you have submitted a total of \$70.00.

Thank you.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

fees

Sincerely,  
SPI AetnaSPI

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/08/2010

Submitted Date 10/08/2010

Respond By Date

Dear John Ciesielski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Appeals & ER Amend, GR-IVLAppealsER-Pol 02 (Form)
- HCR Amend, GR-11741-HCR 01 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 10/08/2010  
Submitted Date 10/08/2010

Dear Rosalind Minor,

### Comments:

additional filing fee

### Response 1

Comments: additional filing fee included

### Related Objection 1

Applies To:

- Appeals & ER Amend, GR-IVLAppealsER-Pol 02 (Form)
- HCR Amend, GR-11741-HCR 01 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

filing fee

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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 10/11/2010	GR- IVLAppeals ER-Pol 02	Certificate	Appeals & ER Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.300	AL GE AIVLAppeals ERPoi V002.PDF
Approved- Closed 10/11/2010	GR-11741- HCR 01	Certificate	HCR Amend Amendmen t, Insert Page, Endorseme nt or Rider	Initial		55.100	AL GE AGR011741H CR 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

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## Amendment

**[Policyholder:** John Doe]

**[Policy No.:** XXXXX]

**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. The following is a summary of the changes in the Policy. This amendment is effective on the dates shown above.

1. Any overall [Plan] [Calendar Year Maximums] [and Plan Lifetime Maximums] that are dollar maximums in any [*Outpatient Prescription Drug Expense Benefits* and] [*Comprehensive Medical Expense Benefits*] section of your *Summary of Coverage* no longer apply. All references to these overall plan dollar maximums that may appear in the *Summary of Coverage*, Policy and any amendments or riders that have been issued to you, are removed.
- [2. The following [*Wellness*] *Benefit* is covered under the plan [and applies to Preferred Care benefits only].

[*Wellness*] *Benefits* will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles and dollar maximum benefits:

- [• Routine Adult Physical Exams (including immunizations and routine vision and hearing screenings);
- Routine Well Baby and Child Exams (including immunizations and routine oral; vision; and hearing screenings);
- Routine Cancer Screenings (which include Mammograms; Prostate Specific Antigen Tests; Digital-Rectal Exams; Fecal Occult Blood Tests; Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies);
- Routine Eye Exams, including refractions (if covered under your Plan); and
- Routine Gynecological Exams (including routine Pap smears).]

These benefits will be subject to age; family history; and frequency guidelines. 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.]

- [3.] Any [monthly; per visit; per day;] [calendar year or annual and] lifetime dollar maximum benefit that applies to an "Essential Service" (as defined by the Federal Department of Health and Human Services) for Preferred Care and Non-Preferred Care 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 *Summary of Coverage*, 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 (include 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 Expenses 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 Payment Percentage; copays; deductibles; [other types of maximums (e.g., day and visit maximums);] referral and certification rules; and any exclusions and limitations that apply to these types of Covered Medical Expenses in your Policy.

- [4. 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 Essential Services Calendar Year Maximum Benefit applies to Preferred Care and Non-Preferred Care expenses combined for Essential Services.]

[5. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under [19-30] years of age.]

[6.] The eligibility rules for children in the *[Eligibility]* section of your Policy have been changed. A child will now be eligible to enroll if he or she is under [26-30] years of age. Any rule that they be a full-time student, not married or solely dependent upon you for support will not apply.

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

[7]. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.

This amendment makes no other changes to the Policy.



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

[Amendment: XXXX]

[Issue Date: October 1, 2010]

SERFF Tracking Number: AENX-G126844617 State: Arkansas  
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46969  
 Company Tracking Number: AR034160100002  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005C Individual - Other  
 Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individua  
 Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Individual-Direct)/AR034160100002

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	10/11/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	10/11/2010
<b>Bypass Reason:</b> not applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	10/11/2010
<b>Bypass Reason:</b> rates filed separately and approved 08/02/2010 under AETN-126731186		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	10/11/2010
<b>Bypass Reason:</b> not applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	10/11/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR PPACA uniform compliance summary.PDF		

SERFF Tracking Number: AENX-G126844617 State: Arkansas  
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46969  
 Company Tracking Number: AR034160100002  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005C Individual - Other  
 Product Name: 2010 HCR- 2010 Health Care Reform (ALIC, Individua  
 Project Name/Number: 2010 HCR- 2010 Health Care Reform (ALIC, Individual-Direct)/AR034160100002

**Item Status:** Approved-Closed  
**Status Date:** 10/11/2010  
**Satisfied - Item:** HCR Indiv Direct CovLTR  
**Comments:**  
**Attachment:**  
 AR HCR Indv Direct Issue CovLTR.PDF

**Item Status:** Approved-Closed  
**Status Date:** 10/11/2010  
**Satisfied - Item:** EOv GR-IVLAppeals-Pol 02, EOv GR-11741-HCR 01  
**Comments:**  
**Attachments:**  
 AL GE EAIvLAppealsERP01 V002.PDF  
 AL GE EAGR011741HCR V001.PDF

**Item Status:** Approved-Closed  
**Status Date:** 10/11/2010  
**Satisfied - Item:** AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT  
**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.

<b>Form Number</b>	<b>Score</b>
GR-IVLAppealsER-Pol 02	51.3
GR-11741-HCR 01	55.1

**Signed:** John W Ciesielski

**Name:** John W Ciesielski

**Title:** Senior Consultant

**Date:** October 4, 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-G126844617	GR-11741-LME and GR-11741	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

## PPACA Uniform Compliance Summary

### SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H16I Individual Health - Major Medical	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 3			
H16I Individual Health - Major Medical	<b>Eliminate Annual Dollar Limits on Essential Benefits</b> 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 2			
H16I Individual Health - Major Medical	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 2			
H16I Individual Health - Major Medical	<b>Prohibit Rescissions</b> – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 3			

## PPACA Uniform Compliance Summary

### SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H16I Individual Health - Major Medical	<b>Preventive Services</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 1			
H16I Individual Health - Major Medical	<b>Extends Dependent Coverage for Children Until age 26</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See form GR-11741-HCR 01			
	Page Number: 3			
H16I Individual Health - Major Medical	<b>Appeals Process</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: See Form GR-IVLAppealsER-Pol 02			
	Page Number: 6			
H16I Individual Health - Major Medical	<b>Emergency Services</b> – 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 checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: Current approved forms are in compliance with this requirement			
	Page Number: N/A			

## PPACA Uniform Compliance Summary

### SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H16I Individual Health - Major Medical	<b>Access to Pediatricians</b> – 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 checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: Current approved forms are in compliance with this requirement			
	Page Number: n/a			
H16I Individual Health - Major Medical	<b>Access to OB/GYNs</b> – 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 checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>  If <b>no</b> , please explain.
	Explanation: Current approved forms are in compliance with this requirement			
	Page Number: n/a			

## PPACA Uniform Compliance Summary

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

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits –</b> 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"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions –</b> Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If <b>no</b> , 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
	<b>Preventive Services</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	<b>Extends Dependent Coverage for Children Until age 26</b> – 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"/> <b>Yes</b> • <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	<b>Appeals Process</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , 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><b>Emergency Services</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	<p><b>Access to Pediatricians</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	<p><b>Access to OB/GYNs</b> – 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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.



**John W. Ciesielski**  
Product & Regulatory Approvals  
Law and Regulatory Affairs  
151 Farmington Ave, RW61  
Hartford, CT 06156  
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Email: Ciesielski@etna.com

October 4, 2010

Insurance Commissioner Jay Bradford  
LIFE AND HEALTH DIVISION  
ARKANSAS INSURANCE DEPARTMENT  
1200 West Third Street  
Little Rock, AR 72201-1904

Subject: **Aetna Life Insurance Company - NAIC No. 00160054**  
**Health Care Insurance Reform Provisions (Effective September 23, 2010)**  
**Grandfathered and Non-Grandfathered Plans**

Policy Amendment Form Nos.:

GR-11741-HCR 01

GR-IVLAppealsER-Pol 02

Dear Commissioner Bradford:

The 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 form. They are in final form rather than being drafts or proofs.

The purpose of this filing submission is to bring Aetna's individual 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.

This form amendments are intended to modify Individual Policy Forms GR-11741-LME and GR-11741 that were approved by your Department on November 8, 2007.

The forms attached to this filing submission will be used for both "grandfathered" and "non-grandfathered" plans. Although the appeals and external review reform applies only to non-grandfathered plans, the above-referenced appeals amendment will be used for both grandfathered and non-grandfathered plans to establish consistency for all plans.

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 currently approved Individual Health Policy forms with regard to the September 23, 2010 HCR changes and has determined that they do not support the following:

- *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. The external review process must mirror the NAIC model.

As to the remaining health care reform changes, 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.

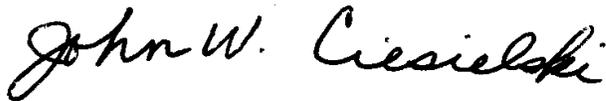
All of the amendment forms submitted with this filing will be issued to existing and new policyholders to amend their forms in response to health care reform.

Variability, as indicated by bracketed material on the form, is required so that only the appropriate language may be reflected on the form. Upon issuance 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 group policy, may vary as the sense demands. An Explanation of Variability has been included.

We request approval of this letter, 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,



John W Ciesielski  
Senior Consultant  
Product & Regulatory Affairs

/Enclosures

# Aetna Life Insurance Company

## Appeals & External Review

### Explanation of Variable Material Policy Amendment Form GR-IVLAppealsER-Pol 02

#### 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 02

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 - Adverse Benefit Determination:* In the second bullet, the words "coverage determinations, including" will be included when the external review process is triggered by the broader coverage determination standard. The rescission paragraph may be expanded to include dental, vision or hearing claims.
14. *Definition - Appeal:* An appeal must be requested in writing but may also be requested orally.

**Explanation of Variable Material**  
**Policy Amendment Form GR-IVLAppealsER-Pol 02**

15. *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.
16. *Full and Fair Review of Claim Determinations and Appeals:* This section may be expanded to include dental, vision or hearing claims.
17. *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.
18. *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.
19. *Appeals of Adverse Benefit Determinations:*
  - a. The reference to "Level Two" 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.
20. *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.
21. *Level Two Appeal - Dental, Vision and Hearing Claims:* This Level Two appeal process description will print if included as part of the policyholder's plan.

**Explanation of Variable Material**  
**Policy Amendment Form GR-IVLAppealsER-Pol 02**

22. *Exhaustion of Process:*
- a. This provision is subject to inclusion or omission based upon a policyholder's plan.
  - b. The reference to "Level Two" will print if applicable to the policyholder's plan.
  - c. The reference to [complaint or] will be included when the Appeals Procedure includes the Complaint provision.
  - d. The last paragraph applies to medical and prescription drug expenses only. It may be expanded to include dental, vision or hearing expenses.
  - e. Important Note Box: This Important Note Box applies to medical and prescription drug expenses only. It may be expanded to include dental, vision or hearing expenses.
23. *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. When external review is triggered by a claim denial due to a determination that the care is not medically necessary or is experimental or investigation then:
    - The language in the first paragraph beginning with "because Aetna determines that..." will appear.
    - In the second bulleted item of the third paragraph, the optional language "of the denial of a claim" will appear.
    - The third bulleted item of the third paragraph will appear.
  - c. When external review is triggered by the broader coverage determination standard, the three items mentioned above will not appear, and the words "any of" will appear in the first sentence of the third paragraph.
  - d. If external review applies to dental, vision and hearing expenses under a policyholder's plan, the "cost of the service, supply or treatment" may be limited to a dollar amount and will vary within the stated range.
  - e. Aetna may incur the entire cost of the External Review for dental, vision and hearing claims (*see the third to the last paragraph*).

**Aetna Life Insurance Company**  
**Explanation of Variable Material**

**Policy Amendment Form:**  
**GR-11741-HCR**  
**01**

**General Comments**

1. ***This amendment applies to both grandfathered and non-grandfathered plans.***
2. 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.
3. 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.
4. Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected.
5. Any references to "calendar year" may be changed to "plan year", "policy year" or "coverage year" as used in a policyholder's forms.
6. The references to prescription drug coverage may be omitted if not applicable under a policyholder's plan.
7. The item number designations (ex. [3.]) will change when text is omitted from the amendment.
8. The bracketed Aetna designations [State] and [Individual-Direct Issue] at the bottom right corner are variable to allow for different descriptions or may be omitted.
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.

**Amendment GR-11741-HCR 01**

11. The "Policyholder Name" and "Policy Number" field is for policyholder-specific information and may not print upon issue.
12. The appropriate policyholder-specific information for the Effective Date will be included upon issue.
13. *Item 1:*
  - a. ***This item will print for both grandfathered and non-grandfathered plans except as noted in item d.***
  - b. The term "Plan" may be revised to "Coverage" or "Insurance", or it may be omitted.
  - c. The appropriate title of the outpatient prescription drug and medical coverage will print.
  - d. The "Calendar Year" maximum ***will only print for non-grandfathered plans.***
14. *Item 2:*
  - a. ***This item will print for non-grandfathered plans only.***
  - b. The term "Wellness" may be changed to "Preventive Care".
  - c. The bracketed phrase "[and applies to Preferred Care benefits only]" may be expanded to include Non-Preferred Care benefits.
  - d. The bracketed list of services is variable to allow Aetna to publish the final list of services, as defined by the Federal Department of Health and Human Services (HHS), when this form is issued to policyholders.

**Aetna Life Insurance Company**  
**Explanation of Variable Material**

15. *Item 3:*
- a. ***This item will print for both grandfathered and non-grandfathered plans except as noted in item c.***
  - b. The bracketed maximums "monthly, per visit, per day" will print if the final regulations, as issued by the Federal Department of HHS, do 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 "calendar year or annual" maximums ***will only print for 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 the Department of Health and Human Services (HHS), when this form is issued to policyholders.
  - e. The list will 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.
  - f. The list will also vary with the types of services that are covered under a policyholder's plan. The wording used to describe the Essential Services may be slightly modified when this amendment is issued in accordance with the terms used in a policy form.
  - g. The term "Mental Disorders" will be revised to the appropriate term as used in a policyholder's forms.
  - h. The term "Substance Abuse" will be revised to the appropriate term as used in a policyholder's forms.
  - i. The reference to "other types of maximums (e.g., day and visit maximums)" will be omitted depending upon the policyholder's plan.
16. *Item 4:*
- a. ***This item will be made available 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 range shown.
17. *Item 5:*
- a. ***This item will print for non-grandfathered plans only.***
  - b. The age limit will vary within the stated range.
18. *Item 6:*
- a. ***This item will print for grandfathered and non-grandfathered plans.***
  - b. The appropriate name of the section reference will print.
  - c. The age limit will vary within the stated range.
19. *Item 7: This item will print for both grandfathered and non-grandfathered plans.*

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

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	AR034160100002
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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"/> <b>FORMS</b> <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"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <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.	<b>Filing Submission Date</b>	
13.	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	<b>Date of Domiciliary Approval</b>	
15.	<b>Filing Description:</b>	
	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.	<b>Certification (If required)</b>	
<b>I HEREBY CERTIFY</b> 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>October 4, 2010</u>

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	AR034160100002	
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Appeals & ER Amend	GR-IVLAppealsER-Pol 02	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02	HCR Amend	GR-11741-HCR 01	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	