

SERFF Tracking Number: AENX-G126812447 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 46793
Company Tracking Number: AR034140100003
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)
Project Name/Number: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)/AR034140100003

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC) SERFF Tr Num: AENX-G126812447 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 46793

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: AR034140100003 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 09/27/2010

Date Submitted: 09/14/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)

Status of Filing in Domicile:

Project Number: AR034140100003

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 09/27/2010

Explanation for Other Group Market Type:

State Status Changed: 09/27/2010

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: \$500.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$0.00	09/14/2010	
Aetna Life Insurance Company	\$500.00	09/14/2010	39499777

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/27/2010	09/27/2010

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Disposition

Disposition Date: 09/27/2010

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 GR-9 & GR-9N CovLTR, HCR GR-9 & GR-9N Attach A	Approved-Closed	Yes
Supporting Document	EOV GR-9 12402 01, EOV GR-9 12411 01, EOV S-08-04 01, EOV S-09-26 01, EOV S-10-06 01, EOV S-11-06 01, EOV S-13-06 01, EOV 28-019 07, EOV 29-010 06	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Preexisting Conditions	Approved-Closed	Yes
Form	Essential Services Calendar Year Maximum Benefit	Approved-Closed	Yes
Form	Appeals & External Amend	Approved-Closed	Yes
Form	Schedule, Basic Essential	Approved-Closed	Yes
Form	Schedule Expense Provisions	Approved-Closed	Yes
Form	Schedule PPO	Approved-Closed	Yes
Form	Schedule MC (POS)	Approved-Closed	Yes
Form	Schedule Comp	Approved-Closed	Yes
Form	Preexisting Conditions	Approved-Closed	Yes
Form	Dependent Elig	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 09/27/2010	GR-9 12402 01	Certificate	Preexisting Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.300	AL GE GR90001240 2 V001 .PDF
Approved- Closed 09/27/2010	GR-9 12411 01	Certificate	Essential Services Amendmen t, Insert Page, Endorseme nt or Rider	Initial	Maximum Benefit	58.400	AL GE GR90001241 1 V001 .PDF
Approved- Closed 09/27/2010	GR- GrpAppeals ER 02	Certificate	Appeals & External Amendmen t, Insert Page, Endorseme nt or Rider	Initial	Amend	50.100	AL GE AGRAppeals ER V002.PDF
Approved- Closed 09/27/2010	GR-9N S- 08-04 01	Certificate	Schedule, Basic Amendmen t, Insert Page, Endorseme nt or Rider	Initial	Essential	0.000	AL GE GR9N00S080 4 V001.PDF
Approved- Closed 09/27/2010	GR-9N S- 09-26 01	Certificate	Schedule Expense Amendmen t, Insert Page, Endorseme nt or Rider	Initial	Provisions	0.000	AL GE GR9N00S092 6 V001.PDF
Approved-	GR-9N S-	Certificate	Schedule PPO	Initial		0.000	AL GE

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Closed	10-06 01	Amendmen	GR9N00S100
09/27/2010		t, Insert Page, Endorseme nt or Rider	6 V001.PDF
Approved- Closed	GR-9N S- 11-06 01	Certificate Schedule MC (POS) Initial Amendmen	0.000 AL GE
09/27/2010		t, Insert Page, Endorseme nt or Rider	GR9N00S110 6 V001.PDF
Approved- Closed	GR-9N S- 13-06 01	Certificate Schedule Comp Initial Amendmen	0.000 AL GE
09/27/2010		t, Insert Page, Endorseme nt or Rider	GR9N00S130 6 V001.PDF
Approved- Closed	GR-9N 28- 019 07	Certificate Preexisting Initial Amendmen Conditions	57.000 AL GE
09/27/2010		t, Insert Page, Endorseme nt or Rider	GR9N002801 9 V007.PDF
Approved- Closed	GR-9N 29- 010 06	Certificate Dependent Elig Initial Amendmen	50.300 AL GE
09/27/2010		t, Insert Page, Endorseme nt or Rider	GR9N002901 0 V006.PDF

Limitations Preexisting Conditions

Important Notes:

- The following preexisting conditions exclusion and limitation does not apply to:
 - A person under [19-30] years of age.
 - A child who is adopted or placed for adoption before attaining 18 years of age.
 - [-Pregnancy.
- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.]

A "preexisting condition" is an injury or disease for which a person:

- received treatment or services; or
- took prescribed drugs or medicines;

prior to the person's Effective Date of Coverage.

See the [*Effective Date of Coverage, Late Enrollment, or Special Enrollment Periods*] section of the [Summary of Coverage], whichever applies, to determine a person's Effective Date of Coverage.

If there is a [probationary] period under the plan, the time used to satisfy the [probationary] period will be credited to the preexisting condition limitation period. [No probationary period credit will apply to late enrollees.]

[Covered Medical Expenses do not include expenses incurred:

- (i) during the [30-365 days] following your Enrollment Date; and
- (ii) after the Effective Date of Coverage under this Plan;

in connection with a "preexisting condition" that manifested itself during the [30-180 day] period preceding your Enrollment Date.]

[Covered Medical Expenses incurred:

- (i) during the [30-365 days] following your Enrollment Date; and
- (ii) after the Effective Date of Coverage under this Plan;

in connection with a "preexisting condition" that manifested itself during the [30-180 day] period preceding your Enrollment Date will include only the first [\$1,000-\$10,000] of such expenses.]

[Coverage will be provided subject to [50%-95%] coinsurance for the treatment of a preexisting condition during the first [30-365 days] [or 30-180 days for late enrollees] following your Effective Date of Coverage.]

Enrollment Date means the earlier of:

- your Effective Date of Coverage under this Plan (or, if applicable, a prior plan of the [Policyholder] that has been replaced by this Plan); or
- the first day of your [probationary] period, if applicable.

Special Rules As To A Preexisting Condition

If a person had creditable coverage which terminated within [63-365 days] prior to his or her Enrollment Date, [any limitation as to a preexisting condition under this Plan will not apply for that person] [any limitation as to a preexisting condition under this Plan will apply for that person only to the extent that it would have applied if he or she had remained covered under the prior creditable coverage].

[Creditable coverage means a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis.
- Medicare.
- Medicaid.
- Health care for members of the uniformed services (including CHAMPUS).
- A program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- The Federal Employees' Health Benefit Plan (FEHBP).
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country).
- Any health benefit plan under Section 5(e) of the Peace Corps Act.
- The State Children's Health Insurance Program (S-CHIP).
- A short-term limited duration policy.]

[Late enrollee means an employee in an Eligible Class who requests enrollment under this Plan after the initial enrollment period. In addition, this means an eligible dependent for whom the employee did not elect coverage within the initial enrollment period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a late enrollee under certain circumstances. See the *Special Enrollment Periods* section of the Summary of Coverage.]

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 **Essential Services** Calendar Year Maximum Benefit applies to **network** care, **other health care** and **out-of-network** care expenses combined for **Essential Services**.]

[This calendar year maximum benefit does not apply to the dental; vision; or hearing expense coverage described in this Booklet-Certificate.]

[**Essential Services** include the following (as defined by the Federal Department of Health and Human Services):

- [• Allergy Testing and Treatment (includes allergy injections);
- Administration of Anesthesia;
- **Birth 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 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; **copays**; deductibles; [other types of maximums (e.g., day and visit maximums);] [referral; and] precertification rules; and any exclusions and limitations that apply to these types of covered medical expenses in your [Booklet-Certificate].

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

[Policyholder: XXXX]

[Group Policy No.: XXXX]

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

October 1, 2010; or

The date you become covered under the Group Policy].

[The group policy noted above has been amended.] The following summarizes the changes in the group policy and the [Booklet-Certificate], describing the policy terms, is amended accordingly]. This amendment is effective on the date shown above.

The following Appeals Procedure, [Exhaustion of Process] [and External Review] provisions replace the same provisions appearing in your [Booklet-Certificate] 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**.]

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:

- seriously jeopardize your life or health;
- 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 – Group 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, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 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.]

[Claim Determinations – Group Disability Income Coverage

Aetna will notify you of a claim decision as soon as possible, but not later than 45 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 45 calendar day claim decision period is required. Such an extension, of not longer than 30 additional calendar days, will be allowed if **Aetna** notifies you within the first 45 calendar day period. If prior to the end of the first 30 calendar day extension period, **Aetna** again determines that due to matters beyond its control a decision cannot be made within that extension period, the claim decision period may be extended for an additional 30 calendar days. **Aetna** must notify you, prior to the end of the first extension period, of the reason requiring the extension and the date by which you can expect a decision.]

[The notice of any extension, by **Aetna**, for any Disability Income Coverage, shall specifically explain:

- The standards on which entitlement to a benefit is based.
- The unresolved issues that prevent a decision on the claim.
- The additional information needed to resolve those issues.

The claimant will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.]

[Claim Determinations – All Other Group Coverage

Aetna will notify you of a claim decision as soon as possible, but not later than 90 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 90 calendar day claim decision period is required. An extension, of not longer than 90 additional calendar days, will be allowed if **Aetna** notifies you within the first 90 calendar day period. The extension notice shall indicate the special reasons requiring an extension of time and the date by which you can expect a decision.]

[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] of **appeal** [depending upon the type of coverage provided under the Plan]. [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 Group Health Claims] [and Group Disability Income Claims] [and 60 calendar days with respect to All Other Group Coverage 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 – Group 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 - Group Health 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**.

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**.]

[Level One Appeal – Group Disability Income Claims

Aetna shall issue a decision within 45 calendar days of receipt of the request for an **appeal**. If **Aetna** determines that due to special reasons an extension of time for claim processing is required, such an extension, of not longer than 45 additional calendar days, will be allowed if **Aetna** notifies you within the first 45 calendar day period. The extension notice shall indicate the special reasons requiring an extension of time and the date by which you can expect a decision.]

[Level One Appeal - All Other Group Claims

Aetna shall issue a decision within 60 calendar days of receipt of the request for an **appeal**. If **Aetna** determines that due to special reasons an extension of time for claim processing is required, such an extension, of not longer than 60 additional calendar days, will be allowed if **Aetna** notifies you within the first 60 calendar day period. The extension notice shall indicate the special reasons requiring an extension of time and the date by which you can expect a decision.]

[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** 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**; or
- 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 the 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 will 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 Group Policy or the [Booklet-Certificate].



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

Aetna Life Insurance Company
(A Stock Company)

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

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: MM/DD/YY]

**Basic [Medical] [Hospital-Surgical] Expense Insurance
[Schedule of Benefits (continued)]**

PLAN FEATURES
The following applies to medical [and prescription drug] covered expenses that are Essential Services :
Essential Services [Calendar Year] Maximum Benefit: [\$750,000-\$10,000,000]

[Schedule of Benefits (continued)]

Maximum Benefit Provisions

Essential Services [Calendar Year] Maximum Benefit

This is 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.

[This **Essential Services** Calendar Year Maximum benefit applies to **network** care, **other health care** and **out-of-network** care expenses combined for Essential Services.]

[This calendar year maximum benefit does not apply to the dental, vision or hearing expense coverage described in this Booklet-Certificate.]

[**Essential Services** include the following (as defined by the Federal Department of Health and Human Services):

- Allergy Testing and Treatment (includes allergy injections);
- Administration of Anesthesia;
- **Birth 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; copays; deductibles**; [other types of maximums (e.g., day and visit maximums);] [referral; and] **precertification rules**; and any exclusions and limitations that apply to these types of **covered expenses** in your Booklet-Certificate.]

[Policyholder : ABC Company
Group Policy Number: 12345
Effective Date: MM/DD/YY]

Aetna Life Insurance Company
[PPO] [Major] [Comprehensive] [Limited] [Medical] Expense Coverage
[Schedule of Benefits (continued)]

PLAN FEATURES

The following applies to medical [and **prescription drug**] covered expenses that are **Essential Services**:

Essential Services [Calendar Year] Maximum Benefit: [\$750,000-\$10,000,000*]

*This [calendar year] maximum benefit applies to [**network**] care, [**other health care**] and [**out-of-network**] care expenses combined for **Essential Services**.

[Policyholder : ABC Company
Group Policy Number: 12345
Effective Date: MM/DD/YY]

Aetna Life Insurance Company
[Major] [Comprehensive] [Limited] [Medical] Expense Coverage
[Gatekeeper PPO] [(POS)]
[Schedule of Benefits]

PLAN FEATURES

The following applies to medical [and **prescription drug**] covered expenses that are **Essential Services**:

Essential Services [Calendar Year] Maximum Benefit: [\$750,000-\$10,000,000*]

*This [calendar year] maximum benefit applies to [**network**] care and [**out-of-network**] care expenses combined for **Essential Services**.

[Policyholder : ABC Company
Group Policy Number: 12345
Effective Date: MM/DD/YY]

Aetna Life Insurance Company
[Major] [Comprehensive] [Limited] [Medical] Expense Coverage
[Schedule of Benefits (continued)]

PLAN FEATURES

The following applies to medical [and **prescription drug**] covered expenses that are Essential Services:

Essential Services [Calendar Year] Maximum Benefit: [\$750,000-\$10,000,000]

Preexisting Conditions Exclusions and Limitations

Important Note:

- The following **preexisting conditions** exclusion and limitation provision will not apply to:
 - A person under [19-30] years of age.
 - A child who is adopted or placed for adoption before attaining 18 years of age.
 - [-Pregnancy.
- Genetic information will not be treated as a **preexisting condition** in the absence of a diagnosis of the condition related to that information.]

A **preexisting condition** is an **illness** or **injury** for which, during the [30-180 day] period immediately prior to your Enrollment Date:

- medical treatment; services; or supplies ;were received; or **prescription drugs or medicines** were taken[; or
- medical advice; diagnosis; care; or treatment; was recommended or received].

If there is a [**waiting**] **period** under the plan, the time used to satisfy the [**waiting**] **period** will be credited to the **preexisting condition** limitation period. [No **waiting period** credit will apply to late enrollees.]

[**Covered expenses do not include** expenses incurred:

- (i) during the [30-365 days] following your Enrollment Date; and
- (ii) after the Effective Date of Coverage under this Plan;

in connection with a "**preexisting condition**" that manifested itself during the [30-180 day] period preceding your Enrollment Date.]

[**Covered expenses** incurred:

- (i) during the [30-365 days] following your Enrollment Date; and
- (ii) after the Effective Date of Coverage under this Plan;

in connection with a "**preexisting condition**" that manifested itself during the [30-180 day] period preceding your Enrollment Date will [include only the first [\$1,000-\$10,000] of such expenses].]

[Coverage will be provided subject to [50%-95%] **coinsurance** for the treatment of a **preexisting condition** during the first [30-365 days] [or [30-180 days] for **late enrollees**] following your Effective Date of Coverage.]

Enrollment Date means the earlier of:

- **Your Effective Date of Coverage** under this [Booklet-Certificate] (or, if applicable, a prior plan of the [Policyholder] that has been replaced by this Plan); or
- The first day of your [**waiting**] **period**, if applicable.

Special Rules as to a Preexisting Condition

[The **preexisting condition** exclusion period will be reduced by the number of days of prior **creditable coverage** you have as of your Effective Date. Any period of **creditable coverage** will not be counted if after such period and before your Enrollment Date, there is a gap of [63-365 days] or more where you had no **creditable coverage**. Neither a **[waiting] period** nor an affiliation period is taken into account to determine a significant break in coverage.]

[If you had **creditable coverage** and such coverage terminated within [63-365 days] prior to your Effective Date, then any limitation as to a **preexisting condition** under this coverage will not apply to you.]

As used above: “**creditable coverage**” means a person’s prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) as of 1996. **Creditable coverage** and **late enrollee** are defined in the [*Glossary*].

Obtaining Coverage for Dependents

Your dependents can be covered [under this Plan]. You may enroll the following dependents, [provided that you are covered under another plan issued by **Aetna**]:

- Your spouse.
- Your dependent children.
- [One-Ten] extended family members.
- [One-Ten] sponsored dependents.
- Your domestic partner who meets the rules set by the [Policyholder].]

Aetna will rely upon the [Policyholder] to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

[Coverage for an Extended Family Member

To be eligible for coverage, an extended family member will need to meet the following requirements:

- Be between the ages of 18 and 65; and
- Be a dependent, as defined in the Internal Revenue Code; and
- Have lived with you for at least six months and will remain a member of your household; and
- Be your mother, father, grandmother, grandfather, stepmother, stepfather, mother-in-law, father-in-law, brother, sister, stepbrother, stepsister, niece, nephew, aunt, uncle, son, daughter, stepson, stepdaughter, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; and
- Not file a joint return for federal income tax purposes; and
- Be a citizen of the United States or its territories, Canada or Mexico; and
- Not be eligible otherwise for coverage under this Plan.]

[Coverage for a Sponsored Dependent

To be eligible for coverage, a sponsored dependent must be:

- Any relative living with you; or
- Any person who, for that year, lives with you and is a member of your household; and
- Dependent upon you for support and meet all of the plan's requirements for dependent eligibility.]

[Coverage for a Domestic Partner

To be eligible for coverage, [you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.] [a domestic partner must meet the following criteria:

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past [3-12months].
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past [3-12 months] and intends to cohabit and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
 - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
 - Common ownership of a **motor vehicle**;
 - Driver's license listing a common address;
 - Proof of joint bank accounts or credit accounts;
 - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
 - Assignment of a durable property power of attorney or health care power of attorney.]

[Coverage for Dependent Children

[To be eligible for Life Insurance, Accidental Death and Personal Loss, Dental, Vision and Hearing Insurance Coverage, a dependent child must be:

- Unmarried; and
- [At least [14-60 days] old, but] under age [19-30] ; or
- Under age [21-30], as long as he or she is a [full-time] student, [at an accredited institution of higher education] [attends school on a regular basis] and solely depends on your support*.

An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- [• Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court-order.
- Your grandchildren in your court-ordered custody.
- Any child whose parent is your child and your child is covered as a dependent under this Plan.
- Any other child who lives with you in a parent-child relationship.]

***Important Note:**

As to Life, Accidental Death and Personal Loss, Dental, Vision and Hearing Insurance Coverage, proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least [12-25] credits or is enrolled as a graduate student with a total course load of at least 9 credits.]

[To be eligible for Prescription Drug and Medical Insurance Coverage, a dependent child must be under [26-30] years of age.

An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- [• Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court-order.
- Your grandchildren in your court-ordered custody.]
- Any child whose parent is your child and your child is covered as a dependent under this Plan.
- Any other child with whom you have a parent-child relationship.]

However, if your dependent child is eligible for such coverage through his or her employer, then your dependent child cannot be enrolled in this Plan.

Coverage for a handicapped child may be continued past the age limits shown above. See [*Handicapped Dependent Children*] for more information.]

[*Important Reminder:

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.]

SERFF Tracking Number: AENX-G126812447 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46793
 Company Tracking Number: AR034140100003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)
 Project Name/Number: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)/AR034140100003

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	09/27/2010
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	09/27/2010
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	09/27/2010
Comments:		
Attachment:		
AR PPACA Uniform Compliance Summary.PDF		

	Item Status:	Status Date:
Satisfied - Item: HCR GR-9 & GR-9N CovLTR, HCR GR-9 & GR-9N Attach A	Approved-Closed	09/27/2010
Comments:		
Attachments:		
ar HCR GR-9 & GR-9N CovLTR.PDF		
HCR GR-9 & GR-9N AttachA.PDF		

	Item Status:	Status Date:
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SERFF Tracking Number: AENX-G126812447 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46793
 Company Tracking Number: AR034140100003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)
 Project Name/Number: 2010 HCR- 2010 Health Care Reform GR-9N/GR-9 (ALIC)/AR034140100003
Satisfied - Item: EOVS GR-9 12402 01, EOVS GR-9 12411 01, EOVS S-08-04 01, EOVS S-09-26 01, EOVS S-10-06 01, EOVS S-11-06 01, EOVS S-13-06 01, EOVS 28-019 07, EOVS 29-010 06
 Approved-Closed 09/27/2010

Comments:

Attachments:

- AL GE EGR90012402 V001 .PDF
- AL GE EGR90012411 V001 .PDF
- AL GE EGR9N0S0804 V001.PDF
- AL GE EGR9N0S0926 V001.PDF
- AL GE EGR9N0S1006 V001.PDF
- AL GE EGR9N0S1106 V001.PDF
- AL GE EGR9N0S1306 V001.PDF
- AL GE EGR9N028019 V007.PDF
- AL GE EGR9N029010 V006.PDF

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	09/27/2010

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-9 12402 01	50.3
GR-9 12411 01	58.4
GR-GrpAppealsER 02	50.1
GR-9N S-08-04 01	0
GR-9N S-09-26 01	0
GR-9N S-10-06 01	0
GR-9N S-11-06 01	0
GR-9N S-13-06 01	0
GR-9N 28-019 07	57
GR-9N 29-010 06	50.3

Signed: John W Ciesielski

Name: John W Ciesielski

Title: Senior Consultant

Date: September 14, 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-G126812447		<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
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19 Explanation: Page Number:	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	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. Explanation: Page Number:	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Eliminate Lifetime Dollar Limits on Essential Benefits Explanation: Page Number:	<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.
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact. Explanation: Page Number:	<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.

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<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.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<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.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<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.
	<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>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<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	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<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	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

PPACA Uniform Compliance Summary

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

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H16G Group Health - Major Medi	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHS/Section 1201 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: Forms GR-9 12402 01 and GR-9N 28-019 07			
H16G Group Health - Major Medi	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 PHS/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-9N S-09-26 01; GR-9N S-08-04 01; GR-9N S-10-06 01; GR-9N S-11-06 01; GR-9N S-13-06 01			
H16G Group Health - Major Medi	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHS/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: Variability of current approved forms support elimination of this maximum.		If no , please explain.	If no , please explain.
	Page Number: N/A			
H16G Group Health - Major Medi	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHS/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.		If no , please explain.	If no , please explain.
	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
H16G Group Health - Major Medi	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHS/Section 1001 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 level of coverage.			
	Page Number: N/A			
H16G Group Health - Major Medi	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 PHS/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-9N 29-010 06			
H16G Group Health - Major Medi	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHS/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: The form listed below supports both GR-9 and GR-9N forms			
	Page Number: Form GR-GrpAppealsER 02			

- 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
H16G Group Health - Major Medi	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: N/A			
H16G Group Health - Major Medi	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: N/A			
H16G Group Health - Major Medi	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: N/A			



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 14, 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**
Group Accident and Health Insurance
Health Care Insurance Reform Provisions (Effective September 23, 2010) -

Grandfathered & Non-Grandfathered Plans:

- *GR-9 & GR-9N Booklet-Certificate Amendment Form: GR-GrpAppealsER 02*
GR-9N Booklet-Certificate Amendment Form: GR-9N-CR1-HCR 01
GR-9 Booklet-Certificate Insert Page Forms: 12402 01, et al
GR-9N Booklet-Certificate Insert Sub-Section Forms: 28-019 07, et al

Dear Commissioner:

The booklet-certificate forms listed above and on the Attachment A to this filing 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.

The purpose of this filing submission is to bring Aetna's group 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 Access to Care Act (PPACA), signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act approved by Congress.

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

PPACA Uniform Compliance Summary

As required by your state, please find the completed PPACA Uniform Compliance Summaries. The *Section B Small/Large Group Health Benefit Plans* portion of the Summaries has been completed for this submission.

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

We intend to use the GR-9N forms listed on Attachment A to this filing with Booklet-Certificate form GR-9N that was approved by your Department on June 23, 2006 and in conjunction with wraparound style master policy form GR-29N that was approved by your Department on June 23, 2006. We intend to use the GR-9 forms listed on Attachment A to this filing with the Wraparound Style Policy form GR-29, approved by your Department on November 17, 1987.

GR-9 Booklet-Certificate Form

Aetna has reviewed our currently approved GR-29 policy and GR-9 booklet-certificate 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.
- *Dollar Limits on Essential Services* - The addition of an Essential Services Calendar Year Maximum that applies to all combined Essential Services.
- *Appeals/External Review Process* - The external review process must mirror the NAIC model.

Therefore, please find attached to this filing the GR-9 forms (listed on the Attachment A) which address the above issues.

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.]

GR-9N Booklet-Certificate Form

Aetna has reviewed our currently approved GR-29N policy and GR-9N booklet-certificate 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.
- *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.
- *Dollar Limits on Essential Services* - The addition of an Essential Services Calendar Year Maximum that applies to all combined Essential Services.
- *Appeals/External Review Process* - The external review process must mirror the NAIC model.

Therefore, please find attached to this filing the GR-9N forms (listed on the Attachment A) which address the above issues.

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.

The booklet-certificate amendment, GR-GrpAppealsER 02, is intended to be used with both the GR-9 and GR-9N booklet-certificate forms that [were] approved on the dates 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.

Variability

Variability, as indicated by bracketed material on the form(s), is required so that only the appropriate language may be reflected on the form(s). 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 group policy, may vary as the sense demands. Detailed Explanations of Variability for the forms have 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

John W Ciesielski
Manager
Product & Regulatory Affairs

Enclosure(s)

**ATTACHMENT A
FORMS LISTING**

GR-9: Booklet-Certificate, Insert Pages		
<i>Form/Insert Page Numbers</i>	<i>Form Name</i>	<i>Flesch Score</i>
GR-9 12402 01	Preexisting Conditions	50.3
GR-9 12411 01	Essential Services Calendar Year Maximum Benefit	58.4]

GR-9 & GR-9N: Amendments		
<i>Form Number</i>	<i>Form Name</i>	<i>Flesch Score</i>
GR-GrpAppealsER 02	Appeals & External Review Amendment	50.1

**ATTACHMENT A
FORMS LISTING**

GR-9N: Schedule of Benefits, Insert Sub-Sections		
<i>Form/Insert Section Numbers</i>	<i>Form Name</i>	<i>Flesch Score</i>
S-08-04 01	Basic Medical	N/A
S-09-26 01	Expense Provisions-Essential Services Calendar Year Maximum	N/A
S-10-06 01	PPO Medical	N/A
S-11-06 01	Gatekeeper PPO Medical	N/A
S-13-06 01	Comp Medical	N/A
		N/A

**ATTACHMENT A
FORMS LISTING**

GR-9N: <i>Booklet-Certificate, Insert Sub-Sections</i>		
<i>Form/Insert Section Numbers</i>	<i>Form Name</i>	<i>Flesch Score</i>
GR-9N 28-019 07	Preexisting Conditions Exclusions and Limitations	57.0
GR-9N 29-010 06	Dependent Eligibility (50.3]

Aetna Life Insurance Company
Explanation of Variable Material

GR-9 Insert Page, 12402
01

General Comments

1. This provision will print based upon a determination by Aetna to include a pre-existing condition limitation, or upon election of the policyholder. Where a law limits preexisting conditions, by group size, it will only be available to groups of that size.
2. Throughout the form are bracketed amounts (ages, time periods, dollar amounts and percentages) which are stated in ranges. These ranges reflect Aetna's standard offerings.
3. 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 or provisions selected by the policyholder.
4. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text and to allow the contractual documents to be system produced.
5. Any references to "Policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
6. Any of the bracketed section references will change to the name of the section that is used within a policyholder's forms.
7. The term "probationary" may be changed to "waiting". This provision will only print for policyholder's who have a probationary period provision.
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.

Insert Page 12402 01

9. *Important Notes:* This box calls out important information to covered persons. It may be modified to add approved language from other areas of the booklet-certificate or the information in the box may be repeated under different areas of the booklet-certificate.
10. There are three options available for the Preexisting condition limitation.
 - a. The *first option* allows for a "full postponement" of benefits (no benefits are payable) for a preexisting condition for the time period within the ranges.
 - b. The *second option* allows for some benefits to be payable for a preexisting condition. Charges incurred for a preexisting condition are subject to a dollar maximum.
 - b. The *third option* allows for some benefits to be payable for a preexisting condition. Charges incurred for a preexisting condition are subject to a reduced coinsurance percentage.

Aetna Life Insurance Company
Explanation of Variable Material

11. *Special Rules as to a Preexisting Condition:*
 - a. The first bracketed phrase allows a full waiver of the preexisting conditions limitation in the event of prior creditable coverage.
 - b. The second bracketed phrase allows for crediting the number of days prior creditable coverage was in force.
 - c. The definitions of creditable coverage and late enrollee may be moved to the Glossary section of the certificate.

Aetna Life Insurance Company

Explanation of Variable Material

GR-9 Insert Page, 12411

01

General Comments

1. This maximum may be included based upon the plan design elected by a policyholder. On January 1, 2014, as required by HHS, this maximum will no longer be available.
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 or provisions selected by the policyholder.
3. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text and to allow the contractual documents to be system produced.
4. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" as used in a policyholder's forms.
5. Any references to "network" may be changed to "in-network", "participating", "preferred care" or some other term of similar meaning as used within a policyholder's forms.
6. Any references to "out-of-network" may be changed to "non-participating", "non-preferred care", "non-network" or some other term of similar meaning as used within a policyholder's forms.
7. 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.

Insert Page 12411 01

8. *First Paragraph:*
 - a. The reference to "prescription drug" will print if applicable to a policyholder's plan.
 - b. The references to the actual dollar amount may be moved to the Summary of Benefits.
 - c. The dollar amount will vary within the stated range.
9. *Second Paragraph:* This paragraph will print for network style plans. The reference to "other health care" will print only for PPO plans.
10. *Third Paragraph:*
 - a. If the policyholder's plan does not include dental, vision or hearing coverage then this paragraph will not print.
 - b. The references to dental, vision or hearing will print in accordance with a policyholder's plan.
 - c. The term "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other term of similar meaning as used in a policyholder's forms.
11. *List of Essential Services:*
 - a. The bracketed list of services is variable to allow Aetna to publish the final list of "Essential 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

- b. The list will vary in accordance with the types of services included in a policyholder's plan. For example, if the plan does not include coverage for Private Duty Nursing then Private Duty Nursing will not be listed. 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 booklet-certificate form.
- c. The term "Mental Disorders" will be revised to the appropriate term as used in a policyholder's forms (e.g., Mental Health, Mental Illness).
- d. The term "Substance Abuse" will be revised to the appropriate term as used in a policyholder's forms (e.g., Alcoholism and Drug Abuse, Chemical Dependency).
- e. The references to "other types of maximums (e.g., day and visit maximums)" and "referral and" will be included if applicable to a policyholder's plan.
- f. This list of Essential Services may be moved to the Glossary.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-08-04
01

General Comments:

1. The appropriate Schedule heading information will print in accordance with a policyholder's plan.
2. The policyholder specific information at the top right corner may be omitted when the Schedule is issued to a policyholder as the information may appear elsewhere in the certificate.
3. The term "Schedule of Benefits" may be changed to "Summary of Benefits" or some other similar term as used in a policyholder's forms.
4. The bracketed maximum amount, which is stated in a range, reflects Aetna's standard offerings.
5. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" based on a policyholder's plan design.
6. 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.

Insert Sub-Section S-08-04 01

7. *Essential Services Calendar Year Maximum Benefit:*
 - a. The maximum will be included when applicable to a policyholder's plan. On January 1, 2014, as required by HHS, this maximum will no longer be available.
 - b. The reference to "prescription drug" will print if applicable to a policyholder's plan.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-26
01

General Comments

1. The maximum will be included when applicable to a policyholder's plan. On January 1, 2014, as required by HHS, this maximum will no longer be available.
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 or provisions selected by the policyholder.
3. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text and to allow the contractual documents to be system produced.
4. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" as used in a Policyholder's forms.
5. Any references to "network" may be changed to "in-network", "participating", "preferred care" or some other term of similar meaning as used within a policyholder's forms.
6. Any references to "out-of-network" may be changed to "non-participating", "non-preferred care", "non-network" or some other term of similar meaning as used within a policyholder's forms.
- [7. The category "Other Health Care" applies to PPO plans. This category allows Aetna to reimburse an insured at a percentage higher than the out-of-network percentage, but lower than the in-network percentage in areas of the country where the PPO network may not be robust. This category also applies, for example, when we do not have contracts with all sub-categories of providers under a broad category, (e.g., radiologists under the category of physicians.)
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.

Insert Page: S-09-26 01

9. *First Paragraph:* The reference to "prescription drugs" will be included if applicable under a policyholder's plan.
10. *Second Paragraph:*
 - a. This paragraph will print for network based plans.
[b. The reference to "other health care" will print only for PPO plans.]
11. *Third Paragraph:*
 - a. If the policyholder's plan does not include dental, vision or hearing coverage then this paragraph will not print.
 - b. The references to dental, vision or hearing will print in accordance with a policyholder's plan.
 - c. The term "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other term of similar meaning as used in a policyholder's forms.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-26
01

12. *List of Essential Services:*

- a. The bracketed list of services is variable to allow Aetna to publish the final list of "Essential Services", as defined by the Federal Department of Health and Human Services (HHS), when this form is issued to policyholders.
- b. The list will vary in accordance with the types of services included in a policyholder's plan. For example, if the plan does not include coverage for Private Duty Nursing then Private Duty Nursing will not be listed.
- c. The term "Mental Disorders" will be revised to the appropriate term as used in a policyholder's forms (e.g., Mental Health, Mental Illness).
- d. The term "Substance Abuse" will be revised to the appropriate term as used in a policyholder's forms (e.g., Alcoholism and Drug Abuse, Chemical Dependency).
- e. The references to "other types of maximums (e.g., day and visit maximums);" and "referral and;" will be included if applicable to a policyholder's plan.
- f. This list of Essential Services may be moved to the Glossary.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-10-06
01

General Comments:

1. The appropriate Schedule heading information will print in accordance with a policyholder's plan.
2. The policyholder specific information at the top right corner may be omitted when the Schedule is issued to a policyholder as the information may appear elsewhere in the certificate.
3. The term "Schedule of Benefits" may be changed to "Summary of Benefits" or some other similar term as used in a policyholder's forms.
4. Any references to "network" may be changed to "in-network", "participating", "preferred" or some other term of similar meaning as used within a policyholder's forms.
5. Any references to "out-of-network" may be changed to "non-participating", "non-preferred", "non-network" or some other term of similar meaning as used within a policyholder's forms.
- [6. The category "Other Health Care" applies to PPO plans. This category allows Aetna to reimburse an insured at a percentage higher than the out-of-network percentage, but lower than the in-network percentage in areas of the country where the PPO network may not be robust. This category also applies, for example, when we do not have contracts with all sub-categories of providers under a broad category, (e.g., radiologists under the category of physicians.)
7. The bracketed maximum amount, which is stated in a range, reflects Aetna's standard offerings.
8. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" based on a policyholder's plan design.
9. 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.

Insert Sub-Section S-10-06 01

10. *Essential Services Calendar Year Maximum Benefit:*
 - a. The maximum will be included when applicable to a policyholder's plan. On January 1, 2014, as required by HHS, this maximum will no longer be available.
 - b. The reference to "prescription drug" will print if applicable to a policyholder's plan.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-11-06
01

General Comments:

1. The appropriate Schedule heading information will print in accordance with a policyholder's plan.
2. The policyholder specific information at the top right corner may be omitted when the Schedule is issued to a policyholder as the information may appear elsewhere in the certificate.
3. The term "Schedule of Benefits" may be changed to "Summary of Benefits" or some other similar term as used in a policyholder's forms.
4. Any references to "network" may be changed to "in-network", "participating", "preferred" or some other term of similar meaning as used within a policyholder's forms.
5. Any references to "out-of-network" may be changed to "non-participating", "non-preferred", "non-network" or some other term of similar meaning as used within a policyholder's forms.
6. The bracketed maximum amount, which is stated in a range, reflects Aetna's standard offerings.
7. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" based on a policyholder's plan design.
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.

Insert Sub-Section S-11-06 01

9. *Essential Services Calendar Year Maximum Benefit:*
 - a. The maximum will be included when applicable to a policyholder's plan. On January 1, 2014, as required by HHS, this maximum will no longer be available.
 - b. The reference to "prescription drug" will print if applicable to a policyholder's plan.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-13-06
01

General Comments:

1. The appropriate Schedule heading information will print in accordance with a policyholder's plan.
2. The policyholder specific information at the top right corner may be omitted when the Schedule is issued to a policyholder as the information may appear elsewhere in the certificate.
3. The term "Schedule of Benefits" may be changed to "Summary of Benefits" or some other similar term as used in a policyholder's forms.
4. The bracketed maximum amount, which is stated in a range, reflects Aetna's standard offerings.
5. Any references to "Calendar Year" may be changed to "Plan Year", "Policy Year" or "Coverage Year" based on a policyholder's plan design.
6. 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.

Insert Sub-Section S-13-06 01

7. *Essential Services Calendar Year Maximum Benefit:*
 - a. The maximum will be included when applicable to a policyholder's plan. On January 1, 2014, as required by HHS, this maximum will no longer be available.
 - b. The reference to "prescription drug" will print if applicable to a policyholder's plan.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
28-019
07

General Comments

1. The provision will print based upon a determination by Aetna to include a pre-existing condition limitation, or upon election of the policyholder. Where a law limits preexisting conditions by group size, it will only be available to groups of that size.
2. Throughout the form are bracketed amounts (percentages and days) which are stated in ranges. These ranges reflect Aetna's standard offerings.
3. 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 or provisions selected by the policyholder.
4. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text to allow the contractual documents to be system produced.
5. The references to "Waiting Period" may be changed to "Probationary Period" or some other term of similar meaning as used in a policyholder's forms. This provision will only print for policyholder's who have a waiting period provision
6. The term "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other term of similar meaning as used in a policyholder's forms.
7. The references to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
8. The maximums shown in "days" may be changed to the equivalent months and vice versa.
9. The bracketed designations [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.

Insert Page: 28-019 07

10. *Important Notes:* This box calls out important information to covered persons. It may be modified to add approved language from other areas of the booklet-certificate or the information in the box may be repeated under different areas of the booklet-certificate.
11. Several bracketed sections apply only to late enrollees and waiting periods. Late enrollee language will only print for groups that cover late enrollees.
12. *Preexisting Condition Definition:* There are 2 options and only one will print as elected by a policyholder.
13. There are three options for the Preexisting condition limitation.
 - a. The *first* option allows for a "full postponement" of benefits (no benefits are payable) for a preexisting condition for the time period in the stated ranges.
 - b. The *second* option allows for some benefits to be payable for a preexisting condition. Charges incurred for a preexisting condition are subject to a dollar maximum.
 - b. The *third* option allows for some benefits to be payable for a preexisting condition. Charges incurred for a preexisting condition are subject to a reduced coinsurance percentage.

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14. *Special Rules as to a Preexisting Condition:*
- a. The first bracketed phrase allows for crediting the number of days prior creditable coverage was in force.
 - b. The second bracketed phrase allows a full waiver of the preexisting conditions limitation in the event of prior creditable coverage.

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General Comments

1. This section will be included when a policyholder's plan includes coverage for dependents. The types of dependents eligible to enroll in a policyholder's plan will vary based upon the policyholder's election and will be reflected throughout this section. The eligible class of dependents and the eligibility dates are determined by the policyholder in compliance with federal and state requirements and as mutually agreed upon with Aetna.
2. Throughout the form are bracketed amounts (ages, time periods and maximum amounts) which are stated in ranges. These ranges reflect Aetna's standard offerings.
3. 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 or provisions selected by the policyholder.
4. The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text to allow the contractual documents to be system produced.
5. The references to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
6. The references to "employee" may be changed to "subscriber", "enrollee", "member" or other term as applicable to the classification of covered persons under the policyholder's plan.
7. The title of the accident insurance coverage applicable to the policyholder's benefit plan will print (i.e. "Accidental Death (ADB)", "Accidental Death and Dismemberment (AD&D)" or "Accidental Death & Personal Loss (ADPL)"). The term "Special" may be added to the title if dependents are covered for this type of accident coverage.
8. *Important Note:* These reminders are provided to call out important information for covered persons. They may be omitted if determined not to be relevant to the plan purchased. They may be modified to add approved language from other areas of the certificate, moved to different areas of the certificate or repeated.
9. The bracketed designations [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.

Insert Page: 29-010 06

10. *Obtaining Coverage for Dependents:*
 - a. The bracketed phrases "under this Plan" and "provided that you are covered, etc" may be included for dependent coverage only plans and the dependent eligibility is tied to a requirement that the employee be covered under another Aetna plan.
 - b. Each bulleted type of dependent may be included or omitted as elected by a policyholder and in accordance with state or federal law.
 - c. Coverage for extended family members and sponsored dependents, if included in the plan, may be limited to a specific number of dependents based upon the policyholder's election.
11. *Coverage for an Extended Family Member:* Coverage for extended family members will be included when requested by the policyholder. It will vary to reflect the criteria set by the policyholder and any of the bulleted items may be omitted.

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12. *Coverage for a Sponsored Dependent:* Coverage of a sponsored dependent will be included when requested by the policyholder. It will vary to reflect the criteria set by the policyholder and any of the bulleted items may be omitted.
13. *Coverage for a Domestic Partner:*
 - a. This section will print when the policyholder's plan includes coverage for domestic partners and will be structured to reflect the specifics of a policyholder's plan.
 - b. If a "Declaration of Domestic Partnership" is not required, the criteria for being a domestic partner may be detailed here.
 - c. If the criteria are included, it will vary to reflect the criteria established by the policyholder.
14. *Coverage for Dependent Children:* This section will print when the policyholder's plan includes coverage for dependent children.
15. *Life Insurance, Accidental Death & Personal Loss (ADPL), Dental, Vision and Hearing:*
 - a. These eligibility requirements will print when the policyholder's plan includes such coverage for dependent children and the eligibility is different than that for medical and prescription drug coverage.
 - b. Any of the listed types of coverage may be omitted.
 - c. The maximum shown in "days" may be changed to the equivalent months and vice versa.
 - d. The eligibility requirements may include criteria for continuing coverage for students beyond the limiting age as elected by the policyholder. The term "full-time" may be expanded to include "part-time". The criteria may include "any school" or be specific to "an accredited institution of higher education".
 - e. The criteria regarding "marital status" or "solely dependent on the employee" may be omitted.
 - f. The eligibility rules for dependent children may vary by type of product. They may be identical to the criteria applicable to the medical coverage.
 - g. Any of the bulleted class of dependents that are bracketed may be omitted based upon a policyholder's plan.
16. *Important Note:*
 - a. Any of the listed types of coverage will be included when applicable to the policyholder's plan.
 - b. Proof of student status may be required each year.
 - c. The term "full-time" may be expanded to include "part-time". The criteria may be specific to undergraduate and graduate students.
17. *Prescription Drug and Medical:*
 - a. This eligibility requirement will print when the policyholder's plan includes medical or medical and prescription drug coverage for dependent children.
 - b. The reference to "Prescription Drug" will print when such coverage is provided along with medical coverage.
 - c. Other coverage lines will be added if the Policyholder elects to extend these eligibility requirement to other coverage under their plan, (e.g., dental). No coverage lines will be mentioned if all coverage under a Policyholder's plan has the same eligibility requirements.
 - d. ***The following paragraph applies only to grandfathered plans: "However, if your dependent child is eligible for such coverage through his or her employer, then your dependent child cannot be enrolled in this Plan".***
 - e. The two bulleted classes of dependents that are in brackets may be omitted from a policyholder's plan.

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18. *Handicapped Dependent Children*: The section reference will be revised to the appropriate title as used in a policyholder's forms.
19. *Important Reminder*: This reminder box will print when the plan includes a "Non-Duplication of Coverage" provision.

Life, Accident & Health, Annuity, Credit Transmittal Document

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

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

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

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	AR034140100003
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7. <input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
	Group	

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
---------------------------------------	----------------------------------

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 checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input checked="" type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Other: <u>inset pages</u>
	<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: _____

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 14, 2010</u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	AR034140100003	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Preexisting Conditions	GR-9 12402 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Essential Services Calendar Year Maximum Benefit	GR-9 12411 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Appeals & External Amend	GR-GrpAppealsER 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Schedule, Basic Essential	GR-9N S-08-04 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Schedule Expense Provisions	GR-9N S-09-26 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Schedule PPO	GR-9N S-10-06 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	Schedule MC (POS)	GR-9N S-11-06 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08	Schedule Comp	GR-9N S-13-06 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09	Preexisting Conditions	GR-9N 28-019 07	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10	Dependent Elig	GR-9N 29-010 06	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	