

SERFF Tracking Number: AENX-G127085140 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 48266
Company Tracking Number: AR036370100002
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2010 HCR- 2010 Health Care Reform Medical Enrollment
Project Name/Number: 2010 HCR- 2010 Health Care Reform Medical Enrollment Form (ALIC)/AR036370100002

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 HCR- 2010 Health Care Reform Medical Enrollment SERFF Tr Num: AENX-G127085140 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved-Closed State Tr Num: 48266

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: AR036370100002 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 03/18/2011
Date Submitted: 03/17/2011 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 HCR- 2010 Health Care Reform Medical Enrollment Form (ALIC)

Status of Filing in Domicile:

Project Number: AR036370100002

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: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 03/18/2011

State Status Changed: 03/18/2011

Deemer Date:

Created By: SPI AetnaSPI

Submitted By: SPI AetnaSPI

Corresponding Filing Tracking Number:

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

PPACA Notes: null

Filing Description:

The enrollment form attached to this filing submission will be used for [both] ["grandfathered"] [and "non-grandfathered"] plans.

The purpose of this filing submission is to bring Aetna's group health enrollment form into compliance with the Health

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Care Insurance Reform (HCR) requirement indicated below 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.

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.

We intend to use the attached enrollment form with:

- [Booklet-Certificate Form GR-9 that was approved by your Department on [date];
- Wraparound Style Policy Form GR-29 that was approved by your Department on [date]]];
- Booklet-Certificate Form GR-9N that was approved by your Department on [date]; and
- Wraparound Style Policy Form GR-29N that was approved by your Department on [date].]

Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Approvals Manager
 CiesielskiJW@Aetna.com
 151 Farmington Avenue
 860-279-1282 [Phone]
 Mail Stop RW61
 860-952-2069 [FAX]
 Hartford, CT 06156

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:

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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	03/17/2011	45692735

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/18/2011	03/18/2011

SERFF Tracking Number: AENX-G127085140 State: Arkansas
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Disposition

Disposition Date: 03/18/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	GR-68000 Enroll Cover Letter	Approved-Closed	Yes
Form	Enrollment/Change form (HCR)	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 03/18/2011	GR-68000- 24 (8-10)	Application/ Enrollment/Change Enrollment form (HCR) Form		Initial		0.000	AL AR 68000- 24 hcrFILING 082010 - Locked.PDF



Enrollment/Change Request

Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)		Customer Code (Optional)	

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.	Enrollment - Check one. <input type="checkbox"/> New Enrollee/Subscriber <input type="checkbox"/> Rehire/Reinstatement Effective Date: / / Date of Rehire/Reinstatement: / / Date of Hire: / /	Change - Check all that apply. <input type="checkbox"/> Add Spouse Date of Event: / / <input type="checkbox"/> Add Dependent Child Reason: _____ <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Control/Suffix/Acct/Plan	Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse Effective Date: / / <input type="checkbox"/> Remove Dependent Child Reason: _____ <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Cancel Coverage	Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin. Date of Loss of Coverage: / / Date of Qualifying Event: / / Continuation of Coverage Expiration Date: / /
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B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone ()	Work Telephone ()
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home Address	Apt. No.	City, State ZIP Code
Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings <input type="checkbox"/> Annually \$ _____ <input type="checkbox"/> Weekly \$ _____

C. Plan Options - Your selection must be offered by your employer.

Check One:

<input type="checkbox"/> Aetna Choice® POS II	<input type="checkbox"/> Managed Choice® POS
<input type="checkbox"/> Aetna HealthFund™	<input type="checkbox"/> Open Choice® PPO
<input type="checkbox"/> Aetna Open Access® Elect Choice	<input type="checkbox"/> Traditional Choice®
<input type="checkbox"/> Aetna Open Access® Managed Choice	<input type="checkbox"/> Aexcel®
<input type="checkbox"/> Elect Choice® EPO	<input type="checkbox"/> Aexcel® Plus
	<input type="checkbox"/> Other _____

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

Check this box if you are refusing coverage for your dependents.

*Provide details for "Yes" responses below.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None".)	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi- capped	Primary Medical Office ID Number	Current Patient	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)	
		Self	<input type="checkbox"/> <input type="checkbox"/>	/ /		Yes * <input type="checkbox"/>	Yes * <input type="checkbox"/>	Yes * <input type="checkbox"/>	Yes N/A		Yes <input type="checkbox"/>	Code	Other
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
 01 - White
 02 - African American or Black
 03 - Hispanic or Latino
 04 - Asian
 05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to Prior Insurance Plan and/or Other Medical Coverage above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your Member Identification Number.

3. Does any dependent listed above live at a different address than the employee? If "Yes," who and what address? Yes No

2. If "Yes" to Other Rx Drug Coverage above, provide effective dates, name & policy number of insurance carrier, HMO or other source and your Member Identification Number.

Special Remarks

E. Employee Signature By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit Aetna Navigator®.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature - Required X	E-Mail Address	Date / /	Primary Language Spoken
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Instructions

Employer - Complete the **Employer Group Information** at the top of the form.

Employee - Complete Sections A - E.

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and Date of Event(s) where requested.

Section B - Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.
- Beneficiary Designation - Complete only if your employer is offering Aetna Life Insurance coverage.

Section C - Plan Options: Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
 - Relationship Code - Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If you or your dependent(s) were covered under your employer's or other **Prior Insurance Plan** or currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** in the space provided in Number 2.
 - **NOTE:** In some instances your medical carrier will differ from your Rx Drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number - Locate the office ID number for the primary care physician from the appropriate provider directory or from "DocFind[®]", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that with the exception of Aetna Rx Home Delivery[®], all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	03/18/2011
Bypass Reason:	not applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/18/2011
Bypass Reason:	not applicable		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	03/18/2011
Comments:			
Attachment:			
	PPACA Uniform Compliance Summary GR-68000.PDF		

		Item Status:	Status Date:
Satisfied - Item:	GR-68000 Enroll Cover Letter	Approved-Closed	03/18/2011
Comments:			
Attachment:			
	ar HCR ALIC Group Enroll GR-68000 CovLTR.PDF		

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-G127085140	GR-9N & GR-29N GR-9 & GR-29	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A ñ Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	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. N/A
	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 Medical	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: This does not appear on the Enrollment Form.		If no , please explain.	If no , please explain.
	Page Number:			
H16G Group Health – Major Medical	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: This does not appear on the Enrollment Form.		If no , please explain.	If no , please explain.
	Page Number:			
H16G Group Health – Major Medical	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/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: This does not appear on the Enrollment Form.		If no , please explain.	If no , please explain.
	Page Number:			
H16G Group Health – Major Medical	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Explanation: This does not appear on the Enrollment Form.		If no , please explain.	If no , please explain.
	Page Number:			

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 Medical	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: This does not appear on the Enrollment Form.			
	Page Number:			
H16G Group Health – Major Medical	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes • <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:.			
	Page Number: GR-68000-24 (8-10) / Page 1 – Between sections C. and D.			
H16G Group Health – Major Medical	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: This does not appear on the Enrollment Form.			
	Page Number:			

- 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 Medical	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: This does not appear on the Enrollment Form.			
	Page Number:			
H16G Group Health – Major Medical	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: This does not appear on the Enrollment Form.			
	Page Number:			
H16G Group Health – Major Medical	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: This does not appear on the Enrollment Form.			
	Page Number:			



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March 17, 2011

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 & Health Insurance Coverage
Health Care Insurance Reform Provisions (Effective September 23, 2010) -
Grandfathered & Non-Grandfathered Plans:
Enrollment/Change Request Form GR-68000-24 (8-10)

Dear Commissioner:

The enclosed form is being submitted for your Department's approval on a general use basis. The enclosed form is new and does not replace any form previously submitted to your Department. It is in final form rather than being a draft or proof.

The enrollment form attached to this filing submission will be used for both "grandfathered" and "non-grandfathered" plans.

The purpose of this filing submission is to bring Aetna's group health enrollment form into compliance with the Health Care Insurance Reform (HCR) requirement indicated below 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.

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.

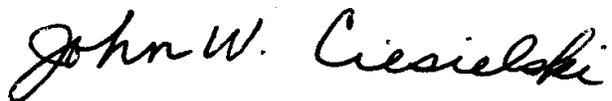
We intend to use the attached enrollment form with: with Booklet-Certificate form GR-9N that was approved by your Department on June 23, 2006 and in conjunction with wraparound style master policy form GR-29N that was approved by your Department on June 23, 2006. We intend to use the GR-9 forms listed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

There is no rate impact associated with this submission.

We request approval of the enclosed form.

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

Sincerely,

A handwritten signature in black ink that reads "John W. Ciesielski". The signature is written in a cursive, flowing style.

John W Ciesielski
Senior Consultant
Product & Regulatory Affairs

Enclosure(s)