

SERFF Tracking Number: AENX-G128312258 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number:
Company Tracking Number: AR053330100003
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2011 HCR- Appeals-External Review/Rescission (ALIC
Project Name/Number: 2011 HCR- Appeals-External Review/Rescission (ALIC GR9/GR9N)/AR053330100003

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2011 HCR- Appeals-External Review/Rescission (ALIC SERFF Tr Num: AENX-G128312258 State: Arkansas

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

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: AR053330100003 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI Disposition Date: 05/01/2012

Date Submitted: 04/30/2012 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2011 HCR- Appeals-External Review/Rescission (ALIC GR9/GR9N) Status of Filing in Domicile:

Project Number: AR053330100003

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

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 05/01/2012

State Status Changed: 05/01/2012

Deemer Date:

Created By: SPI AetnaSPI

Submitted By: SPI AetnaSPI

Corresponding Filing Tracking Number:

PPACA: Grandfathered Immed Mkt Reforms

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

The purpose of this submission is to:

" to file a Rescission provision for use with our [GR-9 and] GR-9N certificate forms; and

" revise Aetna's appeals and external review provisions in response to the "Amendment to the Interim Final Rule" issued collectively by the Department of Labor, the Department of the Treasury and the Department of Health and Human

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Services, and published in the Federal Register on June 24, 2011. More specifically, the revisions reflected in the attached forms concern the following:

- The time period for urgent care claim determinations changing from 24 hours to 72 hours. We are filing these amounts in ranges in the event of future changes to the regulations.
- Clarifying that there are certain exceptions to the exhaustion of process provision that do not result in the member having been considered to have exhausted the appeals process and therefore eligible for external review.
- Expanding the external review language to indicate that claims involving medical judgment may be eligible for external review.

State Narrative:

Company and Contact

Filing Contact Information

Nhu Nguyen, Product & Regulatory Approvals
 Consultant
 151 Farmington Avenue
 Mail Stop RW61
 Hartford, CT 06156

860-273-7546 [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: \$300.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$300.00	04/30/2012	58793493

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2012	05/01/2012

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Disposition

Disposition Date: 05/01/2012

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	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	HCR ALIC GR-9/GR-9N CovLtr	Approved-Closed	Yes
Supporting Document	Attach A	Approved-Closed	Yes
Supporting Document	EOV GR-9N General Prov Insert Page	Approved-Closed	Yes
Supporting Document	EOV GR-9N Rescission Amend	Approved-Closed	Yes
Supporting Document	EOV GR-9N Appeals Insert Page	Approved-Closed	Yes
Supporting Document	EOV GR-9N External Review Insert Page	Approved-Closed	Yes
Supporting Document	EOV GR-9 Rescission Insert Page	Approved-Closed	Yes
Supporting Document	EOV Appeals-ER Cert Amendment	Approved-Closed	Yes
Form	General Provisions (Rescission)	Approved-Closed	Yes
Form	Rescission Amendment	Approved-Closed	Yes
Form	Appeals Insert Page	Approved-Closed	Yes
Form	External Review Insert Page	Approved-Closed	Yes
Form	Appeals-ER Cert Amendment	Approved-Closed	Yes
Form	GR-9 Rescission Insert Page	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 05/01/2012	GR-9N 32-005 03	Certificate	General Provisions Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	AL GE GR9N003200 5 V003.PDF
Approved-Closed 05/01/2012	GR-9N- CR1- Rescission 01	Certificate	Rescission Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	AL GE AGR9N-CR1- Rescission V001.PDF
Approved-Closed 05/01/2012	GR-9N 32-050 01	Certificate	Appeals Insert Page Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	AL GE GR9N003205 0 V001.PDF
Approved-Closed 05/01/2012	GR-9N 32-051 01	Certificate	External Review Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	AL GE GR9N003205 1 V001.PDF
Approved-Closed 05/01/2012	GR- GrpAppeals ER 03	Certificate	Appeals-ER Cert Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	AL GE AGRAppeals ER V003.PDF
Approved-	GR-9	Certificate	GR-9 Rescission	Initial		0.000	AL GE

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Closed 12457 01 Amendmen Insert Page GR90001245
05/01/2012 t, Insert 7 V001 .PDF
Page,
Endorseme
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General Provisions

Type of Coverage

Coverage under this plan is **[non-occupational]** [except for Life Insurance, Accidental Death and Personal Loss, Short Term Disability [Income] and Long Term Disability [Income] coverage]. Only **[non-occupational]** accidental **injuries** and **[non-occupational]** **illnesses** are covered. This plan covers charges made for services and supplies only while the person is covered under this plan.

[Pregnancy related conditions may not be covered under this plan. See the *[Schedule of Benefits]* for more information.]

[Physical Examinations and Evaluations

Aetna will have the right and opportunity to have a **physician** or **dentist** [vocational expert, or other medical or vocational professional] of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at **[Aetna's expense]**.]

Legal Action

[The following information does not apply to Life Insurance.]

[For Accident and Health Insurance

No legal action can be brought to recover payment under any benefit [after 3-5 years] from the deadline for filing claims.]

[For Disability [Income] Insurance

No legal action can be brought to recover payment under any benefit [after 3-5 years] from the final decision date of your last appeal decision.] [, but not later than [after 3-5 years] from the date your eligibility for disability [income] benefit was first denied.]

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs [more than 1-2 years] from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary [for your care or treatment], the operation of this plan and administration of this [Booklet-Certificate], or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** *[Notice of Information Practices]* by calling [Member Services at the number on the back of the ID card].

Additional Provisions

The following additional provisions apply to your coverage.

- [This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.]
- You cannot receive multiple coverage under this plan because you are connected with more than one Policyholder.]
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your [Policyholder] or **Aetna**.
- Your [Policyholder] hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments

An assignment is the transfer of your rights under the group policy to a person you name. [You may assign, as a gift, all ownership of your [Life Insurance and Accidental Death and Personal loss] coverage. **Aetna** [and your Policyholder] must give written consent to the assignment.]

[To request assignment of your [Life Insurance and Accidental Death and Personal Loss coverage] you must complete an assignment form. Forms are available from your Policyholder. Send the completed form to **Aetna** for consent. You may wish to contact legal counsel prior to assigning your [Life Insurance and Accidental Death and Personal Loss coverage] rights. Neither your Policyholder nor **Aetna** guarantees or assumes any obligation concerning the sufficiency or validity of any assignment for purposes of your tax or estate planning.]

[All [other] coverage may be assigned only with the written consent of **Aetna**.] To the extent allowed by law, **Aetna** will not accept [an assignment to an **Out-of Network-Provider**], [provider or facility] including but not limited to,] an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.]

[Claims of Creditors

[Life Insurance and Accidental Death and Personal Loss coverage] benefit payments are exempt from legal or equitable process for your debts, where permitted by law. The exemption applies to the debts of your beneficiary, too.]

[Inspection of Records

Aetna has the right to inspect all of the [Policyholder's] records on the group insurance policy at any reasonable time. This right will extend until the later of:

- 1) [2-5] years after the termination date of the group insurance policy; or
- 2) The date all claims under the group insurance policy have been settled.

The date the group insurance policy is in the Policyholder's possession and may be inspected by you at any time during normal business hours at the Policyholder's office.

Aetna will have the right and opportunity, at its own expense to have your financial records audited as often as **Aetna** may reasonably require at all reasonable times while a claim is pending or payable and for any ongoing recertification.]

[Grace Period

You will be allowed a grace period of [31-90 days] after the due-date for the payment of each [contribution] due after the first [contribution] payment. If [contributions] are not paid by the end of the Grace Period, your coverage will automatically terminate at the end of the Grace Period.]

Misstatements

If any fact as to [the Policyholder or] [you] is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by [the Policyholder or] [you] shall be deemed representations and not warranties. No written statement made by [you] shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to [you] or [your] beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

[As to Life Insurance and Accidental Death and Personal Loss and Disability [Income] Benefit coverage:

During the first two years that your insurance is in force, any statement that you have made may be used by **Aetna** in contesting the validity of that coverage. This also applies to any increase in your coverage for the [one-two years] that follow the effective date of that increase, if [Evidence of Good Health] was required in order for the increase to take effect.

Once coverage (including any increases in coverage) has been continuously in effect for [two] years, the validity of your insurance (or increase in coverage) under this Plan shall not be contested by **Aetna** unless

your statement was in writing on a form signed by you and was fraudulently made in order to obtain that coverage or increase.

Aetna may also contest the validity of your insurance at any time under this Plan for non-payment of premiums when due.]

[As to any Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you [or your dependent] shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for [1-2] years from its effective date.
- No statement made by you [or your dependent] shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for [1-2] years.]

Rescission of Coverage

Aetna may rescind [your] coverage if [you], or the person seeking coverage on [your] behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

[You] will be given [30-60 days] advance written notice of any rescission of coverage.

[As to medical [and prescription drug] coverage only, you have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.]

Aetna Life Insurance Company

Hartford, Connecticut 06156

[Booklet-Certificate] Amendment - *Rescission*

[Policyholder]: [ABC Company]

Group Policy No.: [GP-123456]

Effective Date: This [Booklet-Certificate] Amendment is effective on [January 1, 20XX.] [the later of:
January 1, 20XX; or
The date you become covered under the Group Policy.]

The Group Policy specified above has been amended. The following summarizes the changes in the Group Policy. The [Booklet-Certificate], describing the policy terms, is amended accordingly. This amendment is effective on the date(s) shown above.

The following has been added to the [*General Provisions*] section of your [Booklet-Certificate]:

Rescission of Coverage

Aetna may rescind [your] coverage if [you], or the person seeking coverage on [your] behalf:

- performs an act, practice or omission that constitutes fraud; or
- makes an intentional misrepresentation of material fact.

[You] will be given [30-60 days] advance written notice of any rescission of coverage.

[As to medical [and **prescription drug**] coverage only, you have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent **External Review** Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.]

This amendment makes no other changes to the Group Policy or the [Booklet-Certificate].

[



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

Appeals Procedure

Definitions

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

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

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

[As to medical and **prescription drug** claims only,] an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.]

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] [Aetna or the U.S. Office of Personnel Management, as determined by Aetna] and 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 [24-72] hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within [24-72] 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.

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 **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. 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 may also provide an option to request an **External Review** (if available).]

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
Aetna shall issue a decision within 15 calendar

Care Claim Reduction or Termination)
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 36 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. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.]

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 claim involves medical judgment;
- The care is not **necessary** or appropriate; 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 appropriate 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 the U.S. Office of Personnel Management 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.

The U.S. Office of Personnel Management 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.

Aetna Life Insurance Company

Hartford, Connecticut 06156

[Booklet-Certificate] Amendment - *Appeals Procedure [and External Review]*

[Policyholder: XXXX]

[Group Policy No.: XXXX]

Effective Date: This [Booklet-Certificate] Amendment is effective on [January 1, 20XX] [the later of:

January 1, 20XX; 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**.]

[As to medical and **prescription drug** claims only, an **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.]

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] [Aetna or the U.S. Office of Personnel Management, as determined by Aetna] and 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 [24-72] hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within [24-72] 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.

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 **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. 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 may also provide an option to request an **External Review** (*if available*).]

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 36 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. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.]

[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 claim involves medical judgment;
- the care is not **necessary** or appropriate; 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 appropriate 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 the U.S. Office of Personnel Management 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.

The U.S. Office of Personnel Management 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].

[



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

Rescission of Coverage

Aetna may rescind [a covered person's] coverage if [the covered person], or the person seeking coverage on [a covered person's] behalf:

- performs an act, practice or omission that constitutes fraud; or
- makes an intentional misrepresentation of material fact.

The [covered person] will be given [30-60 days] advance written notice of any rescission of coverage.

[As to medical [and **prescription drug**] coverage only, a covered person has the right to an internal **Appeal** with Aetna and/or the right to a third party review conducted by an independent **External Review** Organization if a covered person's coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.]

SERFF Tracking Number: AENX-G128312258 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053330100003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2011 HCR- Appeals-External Review/Rescission (ALIC
 Project Name/Number: 2011 HCR- Appeals-External Review/Rescission (ALIC GR9/GR9N)/AR053330100003

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/01/2012
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	05/01/2012
Comments:			
Attachment:			
	PPACA Uniform checklist.PDF		

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/01/2012
Comments:			
Attachment:			
	AR_Read Cert.PDF		

		Item Status:	Status Date:
Satisfied - Item:	HCR ALIC GR-9/GR-9N CovLtr	Approved-Closed	05/01/2012
Comments:			
Attachment:			
	AR_HCR GR-9 GR-9N Appeals-Resc CovLtr.PDF		

		Item Status:	Status Date:
Satisfied - Item:	Attach A	Approved-Closed	05/01/2012
Comments:			

SERFF Tracking Number: AENX-G128312258 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053330100003
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: 2011 HCR- Appeals-External Review/Rescission (ALIC
 Project Name/Number: 2011 HCR- Appeals-External Review/Rescission (ALIC GR9/GR9N)/AR053330100003

Attachment:

ALIC HCR Appeals-Resc Attach A.PDF

		Item Status:	Status
			Date:
Satisfied - Item:	EOV GR-9N General Prov Insert Page	Approved-Closed	05/01/2012

Comments:

Attachment:

AL GE EGR9N032005 V003.PDF

		Item Status:	Status
			Date:
Satisfied - Item:	EOV GR-9N Rescission Amend	Approved-Closed	05/01/2012

Comments:

Attachment:

AL GE EAGR9N-CR1-Rescission V001.PDF

		Item Status:	Status
			Date:
Satisfied - Item:	EOV GR-9N Appeals Insert Page	Approved-Closed	05/01/2012

Comments:

Attachment:

AL GE EGR9N032050 V001.PDF

		Item Status:	Status
			Date:
Satisfied - Item:	EOV GR-9N External Review Insert Page	Approved-Closed	05/01/2012

Comments:

Attachment:

AL GE EGR9N032051 V001.PDF

		Item Status:	Status
			Date:

SERFF Tracking Number: AENX-G128312258 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number:
Company Tracking Number: AR053330100003
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2011 HCR- Appeals-External Review/Rescission (ALIC
Project Name/Number: 2011 HCR- Appeals-External Review/Rescission (ALIC GR9/GR9N)/AR053330100003
Satisfied - Item: EOV GR-9 Rescission Insert Page Approved-Closed 05/01/2012
Comments:
Attachment:
AL GE EGR90012457 V001 .PDF

Item Status: **Status**
Date:
Satisfied - Item: EOV Appeals-ER Cert Amendment Approved-Closed 05/01/2012
Comments:
Attachment:
AL GE EAGRAppealsER V003.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-G128312258	GR-9N and GR-29N	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A – 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 – 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 – 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 – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input 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: Amendment and Sub-Section Insert Page			
	Page Number: GR-9N-CR1-Rescission 01 and GR-9N 32-005 03			

PPACA Uniform Compliance Summary

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

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

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

PPACA Uniform Compliance Summary

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

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation: Plans are compliant</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 checked="" type="checkbox"/> No</p> <p>If no, please explain.</p>
	<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: Plans are compliant</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 checked="" 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: Plans are compliant</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 checked="" type="checkbox"/> No</p> <p>If no, please explain.</p>

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

Aetna Life Insurance Company NAIC 60054

This is to certify that the forms referenced below have achieved a Flesh Reading Ease Score as indicated below listed below and comply with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>FORM NUMBER</u>	<u>SCORE</u>
GR-9N 32-005 03	42.5
GR-9N-CR1-Rescission 01	30.6
GR-9N 32-050 01	47.9
GR-9N 32-051 01	49.7
GR-GrpAppealsER 03	47.5
GR-9 12457 01	21.2

Signature:  Date: April 30, 2012
Name: John W Ciesielski
Title: Product and Regulatory Approvals Senior Consultant



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April 30, 2012

Insurance Commissioner Jay Bradford
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
PPACA Provisions: Appeals & External Review and Rescission
Grandfathered & Non-Grandfathered Plans
Booklet-Certificate Form: GR-9, 12457 01 et al
Booklet-Certificate Forms: GR-9N, 32-005 03 et al

Dear Commissioner:

The booklet-certificate forms listed above are being submitted for your Department's review and 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 submission is to:

- to file a Rescission provision for use with our GR-9 and GR-9N certificate forms; and
- revise Aetna's appeals and external review provisions in response to the "Amendment to the Interim Final Rule" issued collectively by the Department of Labor, the Department of the Treasury and the Department of Health and Human Services, and published in the Federal Register on June 24, 2011. More specifically, the revisions reflected in the attached forms concern the following:
 - The time period for urgent care claim determinations changing from 24 hours to 72 hours. We are filing these amounts in ranges in the event of future changes to the regulations.
 - Clarifying that there are certain exceptions to the exhaustion of process provision that do not result in the member having been considered to have exhausted the appeals process and therefore eligible for external review.
 - Expanding the external review language to indicate that claims involving medical judgment may be eligible for external review.

The enclosed forms will be used for both "grandfathered" and "non-grandfathered" plans. It is important to note that, 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.

The enclosed forms are intended to be used with both the GR-9 and GR-9N booklet-certificate forms that were approved on the dates listed below.

- Booklet-Certificate Form GR-9 that was approved by your Department on November 17, 1987;
- Wraparound Style Policy Form GR-29 that was approved by your Department on November 17, 1987;
- Booklet-Certificate Form GR-9N that was approved by your Department on June 23, 2006; and
- Wraparound Style Policy Form GR-29N that was approved by your Department on June 23, 2006.

The enclosed forms will be issued to existing and future policyholders to amend their forms in response to these PPACA regulations.

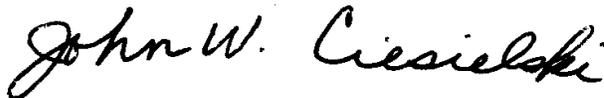
Variability

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

We request approval of the enclosed forms and any attachments

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

Sincerely,



John W Ciesielski
Senior Consultant
Product & Regulatory Affairs +

Attachment A

Booklet Certificate Forms:

Rescission

File this insert page if you are permitted to file forms for the GR-9 in your state.

[GR-9: Rescission Insert Page, 12457 01]

File this amendment only in the states of: AK, CA, ID, IN, KY, MD, NJ, TX, and WA. Puerto Rico is not included in this list because there are currently no existing policyholder's in that state.

[GR-9N: Rescission Amendment, GR-9N-CR1-Rescission 01]

File in all states.

GR-9N: Rescission/General Provisions Sub-Section, 32-005 03

Appeals & External Review

File this amendment for use with the GR-9 if you are permitted to file forms for the GR-9 in your state. This is the same amendment that will be filed in certain states for the GR-9N.

[GR-9: Appeals & External Review Amendment, GR-GrpAppealsER 03]

File this amendment only in the states of: AK, CA, ID, IN, KY, MD, NJ, TX, and WA. Puerto Rico is not included in this list because there are currently no existing Policyholder's in that state. This is the same amendment that will be filed for the GR-9.

[GR-9N: Appeals & External Review Amendment, GR-GrpAppealsER 03]

File in all states.

GR-9N: Appeals Sub-Section, 32-050 01

GR-9N: External Review Sub-Section, 32-051 01

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Explanation of Variability
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General Comments

- 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 customer.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text or may be changed to allow the contractual documents to be system produced.
- Throughout the form are bracketed timeframe amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a Policyholder but only if the amounts are more liberal to the Policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.
- Any references to "Accidental Death and Personal Loss" will change to the specific type of accident insurance coverage applicable to the Policyholder's benefit plan (i.e. "Accidental Death Benefits" or "Accidental Death and Dismemberment Benefits"). The term "Special" may be added to the title if accident insurance coverage is provided for dependents.
- As to the word "Income" as it appears in the references to disability insurance, this word will print in accordance with the type of disability plan included in a Policyholder's plan.
- Any references to "Coverage" may be changed to "Plan".
- The references to "Schedule of Benefits" may be changed to "Summary of Benefits" or some other term of similar meaning as used in a Policyholder's forms.
- The references to "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other term of similar meaning as used in a Policyholder's forms.
- The references to "Policyholder" may be changed to "Employer", "Participating Association", "Plan Sponsor", "Contract Holder", "Participating Employer", "Member Group" or other term of similar meaning.
- Any bracketed titles of the provisions within the form will be revised to the appropriate title as used in a Policyholder's forms.
- The references to "you or your" may be changed to "employee", "employee's", "subscriber", "subscriber's", "enrollee", "member" or other term as applicable to the classification of covered persons under the Policyholder's plan.
- The maximums shown in "days or years" may be changed to the equivalent months and vice versa.
- The page number at the bottom of the form will change as needed.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

Type of Coverage

- Any of the listed benefits will be omitted if not applicable to a Policyholder's plan and only applicable coverages will be included.
- The references to "non-occupational" may be changed to "occupational" or to "non-occupational and occupational".

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- The paragraph that applies to pregnancy-related conditions will print for health and disability plans.

Physical Examinations and Evaluations

- This provision may be omitted in its entirety when it does not apply to the type of coverage included in a Policyholder's plan or if requested by a Policyholder and approved by Aetna.
- The bracketed language "vocational expert, or other medical or vocational professional" will print when applicable to a Policyholder's plan.
- The bracketed phrase "Aetna's expense" may be changed to "no cost to you".

Legal Action

- The sentence that applies to Life Insurance will be omitted if the Policyholder's plan does not include such coverage.
- The paragraph that applies to Accident & Health Insurance will print when such coverage is part of the Policyholder's plan.
- The paragraph that applies to Disability Income Insurance will print when such coverage is part of the Policyholder's plan.

Confidentiality

- The bracketed language "for your care or treatment" will print when the Policyholder's plan includes health coverage. In addition, the phrase will change to "in paying a claim" if the Policyholder's plan is Life Insurance, Accident insurance or Disability insurance coverage only.
- The name of the form "*Notice of Information Practices*" will change to the most current name. As appropriate, either the specific telephone number will be listed or the appropriate source will be reflected.

Additional Provisions

- The first 2 bullets in this provision will be omitted if the Policyholder's plan does not include medical insurance.

Assignments

- The references to Life Insurance and Accident insurance coverage will be omitted if the Policyholder's plan does not include such coverage.

Claims of Creditors

- This provision will be omitted if the Policyholder's plan does not include Life Insurance or some type of accident insurance coverage.

Inspection of Records

- This provision may be omitted from a Policyholder's plan if requested by a Policyholder and approved by Aetna.

Grace Period

- This provision will be omitted when the Policyholder's plan does not require contributions. The references to "contributions" may be changed to "premiums".

Misstatements

- All references to "you and "your" may be expanded to include references to dependents.

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Incontestability

- The paragraphs that apply to Life Insurance and Accident insurance coverage will be omitted when such coverage is not part of a Policyholder's plan.
- The reference to "Evidence of Good Health" will be revised to the term as used in a Policyholder's plan (e.g. "Evidence of Insurability" or "Proof of Good Health").
- The paragraph that applies to "Accident and Health Benefits" will be omitted when such coverage is not part of a Policyholder's plan.
- The references to "or your dependent" will be omitted if dependents are not covered under the Policyholder's plan.
- The paragraph that applies to medical and prescription drug coverage will print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug coverage only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.

Aetna Life Insurance Company

Explanation of Variable Material

Booklet-Certificate Amendment Form: GR-9N-CR1-Rescission 01

General Comments

- This amendment is solely intended to be issued to existing policyholders and will be used to add a Rescission provision to a policyholder's forms.
- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected.
- Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
- 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.
- The name, title and signature of the Aetna officer at the end of the amendment will change to the most current information.
- If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a policyholder's specific documents.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

Booklet-Certificate Amendment: GR-9N-CR1-Rescission 01

1. The appropriate policyholder information may print (Policyholder Name, Group Policy Number and Effective Date). The Policyholder Name and Group Policy Number information may not print upon issue. The bracketed phrase "The group policy noted above has been changed." will print if the policy number is included on the amendment upon issue.
2. The references to "you or your" may be changed to "employee", "employee's", "subscriber", "subscribers", "enrollee", "member" or other term as applicable to the classification of covered persons under the Policyholder's plan.
3. The paragraph that applies to medical and prescription drug coverage will print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug coverage only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.

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Explanation of Variability
GR-9N
32-050
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General Comments

- 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.
- Upon issue, this form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder and this explanation of variability.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
- Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
- 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.
- The page numbers at the bottom of the form will change as needed.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

Definition - Adverse Benefit Determination (Decision)

- The bulleted items that are in brackets will print for health care coverage.
- In the second bullet, the words "coverage determinations, including" will be included when the external review process is triggered by the broader coverage determination standard as required by PPACA regulations.
- The rescission paragraph will always print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug claims only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.

Definition - Appeal

- An appeal must be requested in writing but may also be permitted orally.

Definition - Complaint

- The definition of "complaint" may or may not be incorporated into the provision, depending on whether or not a complaint component is included in a policyholder's plan.
- Any complaint must be expressed in writing but may also be permitted orally.

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Definitions - Concurrent Care Claim Extension, Reduction, Termination and Pre-Service, Post-Service and Urgent Care Claim

- These definitions will print if health care coverage is included in a policyholder's plan.

Full and Fair Review of Claim Determinations and Appeals

- This section applies only to medical and prescription drug claims and appeals only. It may be expanded to include dental, vision or hearing claims.

Claim Determinations - Group Health Coverage

- This section will print when the plan includes health care coverage.
- Written notice of an adverse benefit determination may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing.
- Concurrent Care Claim Reduction or Termination-This continuation provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
- The "hour" limitations in the Urgent Care Claims section are bracketed in the event they need to be revised in accordance with future PPACA and state regulations.

Claim Determinations - Group Disability Income Coverage

- This section may print when the plan includes disability income coverage.

Claim Determinations - All Other Group Coverage

- This section may print when the policyholder's plan includes other coverage such as Life Insurance or accident insurance coverage.

Complaints:

- This provision may be included in a policyholder's plan.
- The term "network" may be revised to "in-network", "participating", "preferred" or some other term of similar meaning as used within a policyholder's forms.
- The complaint must be expressed in writing but may also be permitted orally.

Appeals of Adverse Benefit Determinations

- The reference to "two levels" and "depending upon the type of coverage..." will print in accordance with a policyholder's plan.
- The external review process may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing.
- The appropriate references to the types of coverage will print in accordance with the policyholder's plan.
- The plan may require that the appeal be made in writing.
- The policyholder's name may be required information for the appeal.
- The appeal process may allow that a member submit a written or oral appeal. When the plan requires a written appeal, the references to "calling in an appeal" will be omitted. The address may appear on the back of the ID card or in the notice of adverse benefit determination. Only one of these two options will print.

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- Evidence/Testimony-This provision is bracketed because it will be omitted if the policyholder's plan does not include medical or prescription drug coverage. For medical and prescription drug coverage, it will be included as required and in accordance with the final HHS regulation. It may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.

Level One Appeal - Group Health Claims:

- This section will print if the policyholder's plan includes health care coverage.
- The reference to Level One will be omitted if there is only one level of appeal.
- If the Group Health Appeals Procedure includes only One Level, then the following appeal time periods will apply:
 - Urgent Care Claims will be made in 72 hours;
 - Pre-Service Claims will be made in 30 calendar days; and
 - Post-Service Claims will be made in 60 calendar days.

Level Two Appeal - Group Health Claims:

- This Level Two health appeal process description will print if included as part of the policyholder's plan in accordance with the Federal DOL regulations.

Level One Appeal - Group Disability Income Claims:

- This disability appeal process will print if included as part of the policyholder's plan.

Level One Appeal - All Other Group Claims:

- This section may print when the plan includes other coverage such as Life Insurance or Accident Insurance coverage.

Exhaustion of Process:

- This provision is subject to inclusion or omission based upon a policyholder's plan.
- The reference to "Level One and Level Two" will be changed to reflect the policyholder's plan.
- The reference to "complaint or" will be included when the Appeals Procedure includes the Complaint provision.
- The last paragraph applies to medical and prescription drug expenses only. It may be expanded to include dental, vision or hearing expenses.
- Important Note Box: This Important Note Box applies to medical and prescription drug claims only. It may be expanded to include dental, vision or hearing coverage.

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General Comments

- 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.
- Upon issue, this form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder and this explanation of variability.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
- Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
- The page numbers at the bottom of the form will change as needed.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

External Review

- This External Review provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. The entire provision may be omitted if a policyholder's plan only includes dental, vision or hearing coverage.
- When external review is triggered by a claim denial due to a determination that the care is not medically necessary or appropriate or is experimental or investigational then:
 - The language in the first paragraph beginning with "because Aetna determines that..." will print.
 - In the second bulleted item of the third paragraph, the optional language "of the denial of a claim" will print.
 - The third bulleted item of the third paragraph will print.
- When external review is triggered by the broader coverage determination standard as required by PPACA regulations, the three items mentioned above will not print, and the words "any of" will print in the first sentence of the third paragraph.
- If external review applies to dental, vision and hearing expenses under a policyholder's plan, the "cost of the service, supply or treatment" may be limited to a dollar amount and will vary within the stated range.
- Aetna may incur the entire cost of the External Review for dental, vision and hearing claims (*see the third to the last paragraph*).

Aetna Life Insurance Company

Explanation of Variable Material

GR-9 Insert Page, 12457

01

General Comments

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected.
- 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.
- The page number at the bottom of the form will change as needed.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

Insert Page: GR-9, 12457 01

1. The references to "covered persons" may be changed to "you or your", "subscriber", "enrollee", "member" or other term as applicable to the classification of covered persons under the Policyholder's plan.
2. The paragraph that applies to medical and prescription drug coverage will print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug coverage only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.

Aetna Life Insurance Company

Appeals and External Review

Explanation of Variability

Booklet-Certificate Amendment Form: GR-GrpAppealsER 03

General Comments

- 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.
- Upon issue, this amendment form will be customized in accordance with a policyholder's plan of benefits, the specific forms issued to a policyholder and this explanation of variability.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text.
- Any reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning used in a policyholder's forms.
- 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.
- The page numbers at the bottom of the form will change as needed.
- The name and signature of the Aetna officer at the end of the amendment will change to the most current information.
- If applicable, the Amendment Designation and Issue Date will be inserted at the end of the amendment. These fields are reserved for Aetna's use to allow for the electronic assembly information regarding a policyholder's specific documents.
- 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 postal abbreviation of your state may be added to identify that the form is state specific.

Booklet-Certificate Amendment Form GR-GrpAppealsER 03

1. The appropriate policyholder specific information may print (Policyholder Name, Group Policy Number and Effective Date). The Policyholder Name and Group Policy Number information may not print upon issue. The bracketed phrase "The group policy noted above has been changed." will print if the policy number is included on the amendment upon issue.
2. The lead-in paragraphs will be revised to accurately state the manner in which the provisions will amend the insurance forms of a policyholder. The references to Exhaustion of Process and External Review will print if applicable under a policyholder's plan.
3. *Definition - Adverse Benefit Determination (Decision):*
 - a. The bulleted items that are in brackets will print for health care coverage.
 - b. In the second bullet, the words "coverage determinations, including" will be included when the external review process is triggered by the broader coverage determination standard as required by PPACA regulations.

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- c. The rescission paragraph will always print when the Policyholder's plan includes multiple lines of coverage and the medical and prescription drug lines of coverage is subject to the requirements of PPACA regulations. Aetna may extend the appeals and external review process in the event of rescission to other lines of coverage. When this occurs, the bracketed phrase "As to medical and prescription drug claims only," will be omitted if it applies to all other coverage under a policyholder's plan or it will be expanded to specifically identify the other lines of coverage to which this provision applies.
4. *Definition - Appeal:* An appeal must be requested in writing but may also be permitted orally.
5. *Definition - Complaint:*
 - a. The definition of "complaint" may or may not be incorporated into the provision, depending on whether or not a complaint component is included in a policyholder's plan.
 - b. Any complaint must be expressed in writing but may also be permitted orally.
6. *Definitions - Concurrent Care Claim Extension, Reduction, Termination and Pre-Service, Post-Service and Urgent Care Claim:* These definitions will print if health care coverage is included in a policyholder's plan.
7. *Full and Fair Review of Claim Determinations and Appeals:* This section applies only to medical and prescription drug claims and appeals only. It may be expanded to include dental, vision or hearing claims.
8. *Claim Determinations - Group Health Coverage:*
 - a. This section will print when the plan includes health care coverage.
 - b. Written notice of an adverse benefit determination may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing.
 - c. Concurrent Care Claim Reduction or Termination-This continuation provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
 - d. The "hour" limitations in the Urgent Care Claims section are bracketed in the event they need to be revised in accordance with future PPACA or state regulations.
9. *Claim Determinations - Group Disability Income Coverage:* This section may print when the plan includes disability income coverage.
10. *Claim Determinations - All Other Group Coverage:* This section may print when the policyholder's plan includes other coverage such as Life Insurance or accident insurance coverage.
11. *Complaints:*
 - a. This provision may be included in a policyholder's plan.
 - b. The term "network" may be revised to "in-network", "participating", "preferred" or some other term of similar meaning as used within a policyholder's forms.
 - c. The complaint must be expressed in writing but may also be permitted orally.
12. *Appeals of Adverse Benefit Determinations:*
 - a. The reference to "two levels" and "depending upon the type of coverage..." will print in accordance with a policyholder's plan.
 - b. The external review process may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing.

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- c. The appropriate references to the types of coverage will print in accordance with the policyholder's plan.
- d. The plan may require that the appeal be made in writing.
- e. The policyholder's name may be required information for the appeal.

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- f. The appeal process may allow that a member submit a written or oral appeal. When the plan requires a written appeal, the references to "calling in an appeal" will be omitted. The address may appear on the back of the ID card or in the notice of adverse benefit determination. Only one of these two options will print.
- g. Evidence/Testimony-This provision is bracketed because it will be omitted if the policyholder's plan does not include medical or prescription drug coverage. For medical and prescription drug coverage, it will be included as required and in accordance with the final HHS regulation. It may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. In accordance with the final HHS regulation, it may be duplicated under other parts of the Appeal process.
13. *Level One Appeal - Group Health Claims:*
- a. This section will print if the policyholder's plan includes health care coverage.
- b. The reference to Level One will be omitted if there is only one level of appeal.
- c. If the Group Health Appeals Procedure includes only One Level, then the following appeal time periods will apply:
- Urgent Care Claims will be made in 72 hours;
 - Pre-Service Claims will be made in 30 calendar days; and
 - Post-Service Claims will be made in 60 calendar days.
14. *Level Two Appeal - Group Health Claims:* This Level Two health appeal process description will print if included as part of the policyholder's plan in accordance with the Federal DOL regulations.
15. *Level One Appeal - Group Disability Income Claims:* This disability appeal process will print if included as part of the policyholder's plan.
16. *Level One Appeal - All Other Group Claims:* This section may print when the plan includes other coverage such as Life Insurance or Accident Insurance coverage.
17. *Exhaustion of Process:*
- a. This provision is subject to inclusion or omission based upon a policyholder's plan.
- b. The reference to "Level One and Level Two" will be changed to reflect the policyholder's plan.
- c. The reference to "complaint or" will be included when the Appeals Procedure includes the Complaint provision.
- d. The last paragraph applies to medical and prescription drug expenses only. It may be expanded to include dental, vision or hearing expenses.
- e. Important Note Box: This Important Note Box applies to medical and prescription drug claims only. It may be expanded to include dental, vision or hearing coverage.
18. *External Review:*
- a. This provision may be limited to medical and prescription drug claims only or may be expanded to include other health coverage such as dental, vision and hearing. The entire provision may be omitted if a policyholder's plan only includes dental, vision or hearing coverage.
- b. When external review is triggered by a claim denial due to a determination that the care is not medically necessary or appropriate or is experimental or investigational then:
- The language in the first paragraph beginning with "because Aetna determines that..." will print.
 - In the second bulleted item of the third paragraph, the optional language "of the denial of a claim" will print.
 - The third bulleted item of the third paragraph will print.

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- c. When external review is triggered by the broader coverage determination standard as required by PPACA regulations, the three items mentioned above will not print, and the words “any of” will print in the first sentence of the third paragraph.
- d. If external review applies to dental, vision and hearing expenses under a policyholder's plan, the "cost of the service, supply or treatment" may be limited to a dollar amount and will vary within the stated range.
- e. Aetna may incur the entire cost of the External Review for dental, vision and hearing claims (*see the third to the last paragraph*).