

SERFF Tracking Number: AENX-G128323978 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053350100002
 TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
 Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
 Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver SERFF Tr Num: AENX- State: Arkansas

Review (ALIC SRC Conver

G128323978

TOI: H06 Health - Conversion

SERFF Status: Closed-Approved- State Tr Num:

Closed

Sub-TOI: H06.000 Health - Conversion

Co Tr Num: AR053350100002

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: SPI AetnaSPI

Disposition Date: 05/02/2012

Date Submitted: 05/02/2012

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)

Status of Filing in Domicile:

Project Number: AR053350100002

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/02/2012

State Status Changed: 05/02/2012

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 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 form concern the following:

SERFF Tracking Number: AENX-G128323978 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053350100002
 TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
 Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
 Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

" 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.

We intend to use the policy amendment form with the Limited Major Medical Conversion Policy Form GR-96332 that was approved on June 12, 2006.

State Narrative:

Company and Contact

Filing Contact Information

Nhu Nguyen, Product & Regulatory Approvals

Consultant

151 Farmington Avenue

860-273-7546 [Phone]

Mail Stop RW61

860-952-2069 [FAX]

Hartford, CT 06156

Filing Company Information

Aetna Life Insurance Company

CoCode: 60054

State of Domicile: Connecticut

151 Farmington Avenue

Group Code: 1

Company Type:

Hartford, CT 06156

Group Name: Aetna

State ID Number:

(860) 273-7546 ext. [Phone]

FEIN Number: 06-6033492

Filing Fees

Fee Required? Yes

Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	05/02/2012	58847204

SERFF Tracking Number: AENX-G128323978 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number:
Company Tracking Number: AR053350100002
TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/02/2012	05/02/2012

SERFF Tracking Number: AENX-G128323978 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number:
Company Tracking Number: AR053350100002
TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Disposition

Disposition Date: 05/02/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-G128323978 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053350100002
 TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
 Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
 Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	HCR SRC Conversion CovLtr	Approved-Closed	Yes
Supporting Document	EOV Policy Amendment	Approved-Closed	Yes
Form	Appeals-ER Policy Amendment	Approved-Closed	Yes

SERFF Tracking Number: AENX-G128323978 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053350100002
 TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
 Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
 Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-IVL SRCAppeals	Policy/Cont ract/	Appeals-ER Policy Fraternal Amendment	Initial		0.000	AL GE AIVLSRCApp ealsERPol V003.PDF
05/02/2012	sER 03	al	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider				

Aetna Life Insurance Company

Hartford, Connecticut 06156

Policy Amendment – Grievance and External Review

Policyholder: [XXXX]

Deleted: [

Policy No.: [XXXX]

Deleted: [

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

Deleted: [Booklet-Certificate]

January 1, 20XX; or

Deleted: 2012

The date you become covered under the Policy].

Deleted: 2012

The policy noted above has been amended. The following summarizes the changes in the Policy and is amended accordingly. This amendment is effective on the date shown above.

The following Grievance, Procedure and External Review provisions replace the same provisions appearing in your Policy or any amendment or rider issued to you:

Deleted: Appeals

Grievance Procedure

Deleted: Appeals

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**.

Deleted: [

Deleted: [

Deleted: [

Deleted:]

Deleted: An **adverse benefit determination** also means the termination of a covered person's coverage back to the original effective date (rescission) as it applies under any rescission provision appearing in the Policy. **Appeal:** An [oral or] written request to Aetna to reconsider an **adverse benefit determination**.¶

Grievance: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan. This includes a written complain submitted by or on behalf of an enrollee regarding the:

- availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- claims payment, handling or reimbursement for health care services; or
- matters pertaining to the contractual relationship between an enrollee and Aetna.

Deleted: [

Deleted: Complaint

Deleted: [

Deleted:]

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

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

Deleted: [

Deleted: [

Deleted: [State]

GR-IVL SRCAppealsER 03

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

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
- The health benefit plan terminates before the health care services are provided; or
- The covered person's coverage under the health benefit plan terminates before the health care services are provided.

Formatted: Indent: Left: 0", Bulleted + Level: 1 + Aligned at: 0.79" + Tab after: 1.04" + Indent at: 1.04", Tabs: 0.25", List tab + Not at 1.04"

Formatted: Bullets and Numbering

Deleted: <#> Booklet-¶

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 Aetna or the U.S. Office of Personnel Management, as determined by Aetna made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Deleted: [

Formatted: Font color: Black

Formatted: Font color: Black

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

Deleted: appeals

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."

Deleted: [

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

Deleted: [

- 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.

Deleted: [

Full and Fair Review of Claim Determinations and Appeals

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

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

Claim Determinations – Health Coverage

Deleted: /

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. 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**.

Deleted: [As to medical and prescription drug claims,] i

Deleted: [State]

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than **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 **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, **by telephone to the Provider within 24 hours; and written or electronic notification of the Provider notification, to the covered person and Provider within 1 working day.**

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 except when a covered person receives an emergency service that requires immediate post evaluation or post stabilization services. Aetna shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within thirty minutes, such services shall be deemed approved.**

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 a **Grievance**.

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:

- Such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
- The health benefit plan terminates before the health care services are provided; or
- The covered person's coverage under the health benefit plan terminates before the health care services are provided.

Deleted: ¶

Deleted: [24-

Deleted:]

Deleted: [24-

Deleted:]

Deleted: *Full and Fair Review of Claim Determinations and Appeals*¶

¶ 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.¶

Deleted: 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.

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Deleted:]

Deleted: [

Deleted:

Deleted:]

Deleted: [

Formatted: Bullets and Numbering

Formatted: Indent: Hanging: 1.04", Bulleted + Level: 1 + Aligned at: 0.79" + Tab after: 1.04" + Indent at: 1.04", Tabs: 0.25", List tab + Not at 1.04"

Formatted: Indent: Left: 0.02"

Deleted: [State]

If you file a **Grievance**, coverage under the plan will continue for the previously approved course of treatment until a final **Grievance** 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 **Grievance** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Grievance

If you are dissatisfied with the service you receive from the Plan, **the contractual relationship between you and Aetna**, or want to complain about an **network provider** you must call or write **Member Services** within **180** calendar days of the incident. **Failure to call or write Member Services in 180 calendar days of the incident will not subject the you to a claim denial, unless this failure operates to prejudice the rights of the Plan.** The **Grievance** 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 send you an acknowledgement letter of the Grievance within 10 working days.

Aetna will review the information and provide you with a written response on or before the 20th working day of the receipt of the Grievance unless the **investigation cannot be completed in this time.** If **Aetna** is unable to make a decision regarding the **Grievance** within the **20th working day**, **Aetna** will notify you in writing **on or before the 20th working day** and the investigation shall be completed within 30 working days. **Aetna**, will notify you in writing of the delay and specify the reasons for which additional time is needed regarding the investigation.

Aetna shall notify you in writing of the resolution of a **grievance** within 5 working days after completing the investigation.

The notice will include:

- a statement of the decision by **Aetna**;
- a statement of the reasons, policies and procedures that are the basis for the decision;
- notice of your rights to appeal the decision; and

Aetna shall notify you in writing of the resolution of the **Grievance** decision within 15 working days after completing the investigation.

Expedited Grievance Review Procedure

You (or the individual acting on your behalf) have the right to request an expedited **Grievance** review. An expedited **Grievance** review may be available if you have a medical condition where the time required to complete a standard **Grievance** would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, your expedited **Grievance** review may be submitted orally or in writing.

Aetna will notify you orally within 72 hours after receiving a request for an expedited **Grievance** review of **Aetna's** determination and shall provide a **written confirmation of the decision within 3 working days of the notification.**

Appeals of Adverse Benefit Determinations

You may submit a **Grievance**, if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level of **Grievance**. A **final adverse benefit determination** notice will also provide an option to request an **External Review**.

GR-IVL SRCAppealsER 03

MQ

Deleted: [As to medical and prescription drug claims only.]

Deleted: i

Deleted: n appeal

Deleted: appeal

Deleted: appeal

Deleted:]

Deleted: /

Deleted: Complaints

Deleted: [

Deleted:]

Deleted: [

Deleted:]

Deleted: 30

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Font color: Black

Formatted: Font: 11 pt, Font color: Black

Deleted: complaint

Deleted: 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.

Deleted: appeal[

Deleted:] [must be submitted]

Deleted: [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 not (... [1])

Deleted: n

Deleted: appeal

Deleted: [

Deleted:] [or two levels]

Deleted: appeal

Deleted: [depending upon the ty (... [2])

Deleted:]

Deleted: [State]

You have 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your Level One **Grievance**. Your **Grievance** may be submitted orally or 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 **Grievance**.
- Any other information you would like to have considered.

An appeal of an Urgent Care Claim may be submitted either orally or in writing.

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

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

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

You may be allowed to provide evidence or testimony during the Grievance process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Grievance – Health Claims

For Utilization Review

A review of a Level One **Grievance** 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 an **oral** decision within 36 hours of receipt of the request for an **Grievance**. **A written confirmation of the decision will be provided within 3 working days of the notification.**

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

Aetna will send you an acknowledgement letter of the Grievance within 10 working days and shall issue a decision within 15 calendar days of receipt of the request for an Grievance.

Post-Service Claims

Aetna will send you an acknowledgement letter of the Grievance within 10 working days of receipt of the request for an appeal. Aetna will review the information and provide you with a written notice on or before the 20th working day of the receipt of the Grievance if the investigation cannot be completed in this time. The investigation shall be completed within 30 calendar days of receipt of the request for an Grievance.

For Other Than Utilization Review

A level one Grievance of an Adverse Benefit Determination shall be provided by Aetna personnel not involved in making the Adverse Benefit Determination.

Deleted: [

Deleted: with respect to Group Health Claims] [and Group Disability Income Claims] [and 60 calendar days with respect to All Other Group Coverage claims]

Deleted: Appeal

Deleted: appeal

Deleted: [

Deleted:] [must be submitted]

Deleted: [

Deleted:]

Formatted: Indent: First line: 0", Tabs: 0.25", Left

Deleted: .

Deleted: [

Deleted: appeal

Deleted: appeal

Deleted:]

Deleted: [

Deleted: appeal

Deleted: appeal

Deleted:]

Deleted: appeal

Deleted: [As to medical and prescription drug claims only,

Deleted: y

Deleted: appeal

Deleted:]

Deleted: [

Deleted: Appeal

Deleted: – Group Health Claims

Deleted: Appeal

Deleted: ¶

Deleted: appeal

Deleted: Section Break (Next Page) .

Deleted: Aetna

Deleted:

Deleted: appeal

Deleted: Aetna shall issue a decision

Deleted: appeal

Deleted: [State]

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

Aetna shall issue a decision within 24 hours of receipt of the request for a **Grievance**.

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 **Grievance**.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a **Grievance**.

Any decision made by the Grievance Advisory Panel will include a notice of your, Aetna's or the plan sponsor's right to file an **Grievance** with the Office of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration. Such notice will include the address and toll-free telephone number of the Director's office.

Level Two Grievance

If Aetna upholds an **adverse benefit determination** at the first level of **Grievance**, 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 **Grievance**. The **Grievance** must be submitted within 180 calendar days following the receipt of a decision of a Level One **Grievance**.

Grievance Advisory Panel is comprised of; Other Enrollees; Representatives of the of the health carrier that were not involved in the circumstances giving rise to the grievance; and where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

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

Aetna shall issue a decision within 24 hours of receipt of the request for a Level Two **Grievance**. A written confirmation of the decision will be provided within 3 working days of the notification.

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

Aetna will send you an acknowledgement letter of the **Grievance** within 10 working days and shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Grievance**.

Post-Service Claims

Aetna will send you an acknowledgement letter of the **Grievance** within 10 working days of receipt of the request for an appeal. Aetna will review the information and provide you with a written notice on or before the 20th working day of the receipt of the **Grievance** if the investigation cannot be completed in this time. The investigation shall be completed within 30 calendar days of receipt of the request for a Level Two **Grievance**.

Any decision made by the Grievance Advisory Panel will include a notice of your, Aetna's or the plan sponsor's right to file an Appeal with the Office of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration. Such notice will include the address and toll-free telephone number of the Director's office.

You may contact the Missouri Department of Insurance, Financial Institutions and Professional Registration for assistance at any time using the following address:

Deleted: ¶
[Level Two Appeal - Group Health Claims]¶
¶
If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**. ¶
Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim**, a **Pre-Service Claim**, or a **Post-Service Claim** shall be provided by Aetna personnel. They shall not have been involved in making the **adverse benefit determination**.¶
¶
Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)¶
¶
Aetna shall issue a decision within 24 hours of receipt of the request for a Level Two **Appeal**.¶
¶
Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)¶
¶
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.¶
¶
Post-Service Claims¶
¶
Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.¶
[Exhaustion of Process]¶
¶
You must exhaust the applicable [Level One and Level Two] processes of the Appeal Procedure before you:¶
¶
• . Contact the [insert state name] Department of Insurance to request an investigation of a [complaint or] **appeal**; or¶
• . File a complaint or **appeal** with the [insert state name] Department of Insurance; or ¶
• . Establish any:¶
¶
litigation;¶
¶
arbitration; or¶
¶
administrative proceeding;¶
¶
regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.]

Deleted:
Deleted: [State]

Missouri Department of Insurance, Financial Institutions and Professional Registration
Office of the Director
P.O. Box 690
Jefferson City, Missouri 65102-0609
Toll-Free Number: 1-800-726-7390

No such **Grievance** procedure shall act as a bar to any suit in a court of competent jurisdiction instituted by any such enrollee, or as a bar to any defense thereto by **Aetna**.

In the event there is a conflict between the outcomes of the **Grievance** Procedure and any such suit, the outcome of the suit in a court of competent jurisdiction shall prevail.

Important Note:

If **Aetna** does not adhere to all claim determination and **Grievance** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **Grievance** 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 **Grievance** straight to an **External Review**. Your claim or internal **Grievance** *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

You may receive an adverse benefit determination or final adverse benefit determination notice.

In of these situations, you may request an **External Review** if you or your **Provider** disagrees with **Aetna's** decision. An **external review** is a review by an Independent Review Organization/External Review Organization (ERO) assigned by the Director of the Department of Insurance made up of **Physicians** or other appropriate health care **Providers**. The ERO must have expertise in the problem or question involved.

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 by **Aetna**.
- You qualify for a faster review as explained below.

Aetna's notice of adverse benefit determination or final adverse benefit determination describes the process to follow if you wish to pursue an **External Review** and includes a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to **Aetna** after the date you receive 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 their request.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the *Request for External Review Form*, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 45 calendar days of **Aetna's** receipt of the **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 a **Experimental or Investigational Procedure** 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 inpatient confinement; or health service for which you received **Emergency Service**, but has 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 they 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**.

For more information about the **Grievance** or **External Review** processes, call the Member Services telephone number shown on the **Member's** ID card.



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

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

- Deleted: Aetna's
- Deleted: claim denial letter
- Deleted: notice of adverse benefit determination or final adverse benefit determination describes the process to follow if you wish to pursue an E
- Deleted: e
- Deleted: xternal
- Deleted: r
- Deleted: Review
- Deleted: , including
- Deleted: and includes a copy of the Request for External Review Form.¶
- ¶
- You must submit the Request for External Review Form to Aetna within 123 calendar days of the date you receive the adverse benefit determination (... [3])
- Formatted (... [4])
- Deleted: final claim denial letter
- Formatted: Font: 11 pt
- Deleted: . You also must includ (... [5])
- Deleted: final claim denial letter
- Deleted: notice and all other per (... [6])
- Deleted: Aetna will abide by th (... [7])
- Deleted: [
- Formatted (... [8])
- Deleted: endanger
- Deleted: seriously jeopardize
- Deleted:
- Deleted: your life or health; or ¶ (... [9])
- Deleted: e
- Deleted: stay
- Deleted: ; or health service for (... [10])
- Deleted: emergency
- Deleted: care
- Deleted: Service, but has
- Deleted: ve
- Deleted: not been discharged (... [11])
- Deleted: — — —Page Break— — —
- Deleted: 3 to 5 calendar days
- Deleted: 72 hours after Aetna (... [12])
- Deleted: and for the cost of the (... [13])
- Formatted (... [14])
- Deleted:]
- Formatted: Font: 11 pt
- Deleted: .¶ (... [15])
- Formatted (... [16])
- Deleted: [State]

[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.

]

[depending upon the type of coverage provided under the Plan]. [As to medical and **prescription drug** claims,

and includes a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to **Aetna** within 123 calendar days of the date you receive the adverse benefit determination or final adverse benefit determination notice

Font: 11 pt, Italic, Font color: Black

Font: 11 pt

Font: 11 pt, Italic, Font color: Black

Font: 11 pt

. You also must include a copy of the

notice and all other pertinent information that supports their request.

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

•

Page 9: [7] Deleted	A738091	11/16/2011 6:14:00 AM
---------------------	---------	-----------------------

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 they wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO

Page 9: [8] Formatted	A738091	11/16/2011 9:56:00 AM
-----------------------	---------	-----------------------

Font: 11 pt, Italic, Font color: Black

Page 9: [8] Formatted	A738091	11/16/2011 9:56:00 AM
-----------------------	---------	-----------------------

Font: 11 pt

Page 9: [8] Formatted	A738091	11/16/2011 9:56:00 AM
-----------------------	---------	-----------------------

Font: 11 pt, Italic, Font color: Black

Page 9: [8] Formatted	A738091	11/16/2011 9:56:00 AM
-----------------------	---------	-----------------------

Font: 11 pt

Page 9: [9] Deleted	A738091	11/16/2011 6:14:00 AM
---------------------	---------	-----------------------

your life or health; or

- jeopardize your ability to regain maximum function; or
- if the Adverse Benefit Determination relates to a **Experimental or Investigational Procedure** 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 inpatient confinement

Page 9: [10] Deleted	A738091	11/16/2011 6:14:00 AM
----------------------	---------	-----------------------

; or health service for which you received **E**

Page 9: [11] Deleted	A738091	11/16/2011 6:14:00 AM
----------------------	---------	-----------------------

not been discharged from a facility.

Faster reviews are decided within

Page 9: [12] Deleted	A738091	11/16/2011 6:14:00 AM
----------------------	---------	-----------------------

72 hours after **Aetna** receives the request.

Page 9: [13] Deleted	A738091	11/16/2011 6:14:00 AM
----------------------	---------	-----------------------

and for the cost of the **external review**

Page 9: [14] Formatted	A738091	11/16/2011 9:56:00 AM
------------------------	---------	-----------------------

Font: 11 pt, Bold, Font color: Black

Page 9: [15] Deleted	A738091	11/16/2011 6:14:00 AM
----------------------	---------	-----------------------

.

For more information about the Complaints **and Appeals** or **External Review** processes, call the Member Services telephone number shown on the **Member's** ID card]

Page 9: [16] Formatted Font: 11 pt, Bold	A738091	11/16/2011 9:56:00 AM
Page 9: [16] Formatted Font: 11 pt	A738091	11/16/2011 9:56:00 AM
Page 9: [16] Formatted Font: 11 pt, Bold, Font color: Black	A738091	11/16/2011 9:56:00 AM
Page 9: [16] Formatted Font: 11 pt	A738091	11/16/2011 9:56:00 AM

SERFF Tracking Number: AENX-G128323978 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number:
 Company Tracking Number: AR053350100002
 TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
 Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
 Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/02/2012
Comments:		
Attachment:		
AR_Idv SRC_Read Cert.PDF		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	05/02/2012
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	05/02/2012
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	05/02/2012
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	05/02/2012
Comments:		
Attachment:		
AR 2011 HCR SRC Conversion-PPACA Checklist.PDF		

SERFF Tracking Number: AENX-G128323978 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number:
Company Tracking Number: AR053350100002
TOI: H06 Health - Conversion Sub-TOI: H06.000 Health - Conversion
Product Name: 2011 HCR- Appeals-External Review (ALIC SRC Conver
Project Name/Number: 2011 HCR- Appeals-External Review (ALIC SRC Conversion)/AR053350100002

Item Status: Approved-Closed
Status Date: 05/02/2012
Satisfied - Item: HCR SRC Conversion CovLtr
Comments:
Attachment:
AR_HCR SRC_ Appeals-Resc CovLtr.PDF

Item Status: Approved-Closed
Status Date: 05/02/2012
Satisfied - Item: EOVS Policy Amendment
Comments:
Attachment:
AL GE EAIVLSRCAppealsERP01 V003.PDF

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

Aetna Life Insurance Company NAIC 60054

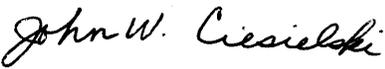
This is to certify that the form (s) referenced below has/have achieved a Flesh Reading Ease Score as indicated below listed below and comply with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258 cited as the Life and Disability Insurance Policy Language Simplification Act.

FORM NUMBER

SCORE

GR-IVLAppealsER-Pol 03

50.1

Signature:  Date: May 2, 2012
Name: John W Ciesielski
Title: Product and Regulatory Approvals Senior Consultant

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-G128323978	GR-96332	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H06 Health Conversion	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number: N/A			
H06 Health Conversion	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number: N/A			
H06 Health Conversion	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: N/A			
H06 Health Conversion	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Current forms support this requirement			
	Page Number: N/A			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
H06 Health Conversion	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number: N/A			
H06 Health Conversion	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input 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: N/A			
H06 Health Conversion	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Amendment			
	Page Number: GR-IVLAppeals-Pol 03			
H06 Health Conversion	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Plans are compliant			
	Page Number: N/A			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

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

PPACA Uniform Compliance Summary

Reset Form

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 type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

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

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

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

PPACA Uniform Compliance Summary

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

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



John W. Ciesielski

Product & Regulatory Approvals

Law and Regulatory

151 Farmington Ave, RW61

Hartford, CT 06156

(845) 279-1282

Fax: (860) 952-2065

Email: Ciesielskijw@aetna.com

May 2, 2012

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

RE: Aetna Life Insurance Company
Form #: GR-IVLAppealsER-Pol 03

Dear Commissioner Bradford:

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

The purpose of this submission is to 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 form 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 amendment form 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.

PPACA Uniform Compliance Summary

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

We intend to use the policy amendment form with the Limited Major Medical Conversion Policy Form GR-96332 that was approved on 6/12/2006.

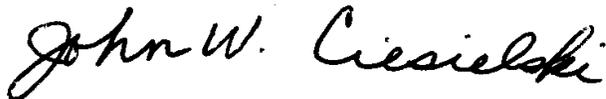
The enclosed forms will be issued to existing and future policyholders to amend their forms in response to these PPACA regulations.

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.

There is no rate impact for the above conversion policies.

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.

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

John W Ciesielski
Senior Consultant
Product & Regulatory Approvals

Aetna Life Insurance Company

Appeals & External Review

Explanation of Variable Material Policy Amendment Form GR-IVL SRCAppealsER 03

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.

1. The effective date information is standard and will print with group specific information.
2. The name and signature of the Aetna officer at the end of the amendment will change to the most current information.

Deleted: As the above-referenced appeals amendment will be used for group and individual conversion, all variable references to "Group Agreement" will either be omitted, or replaced with "Certificate", when the amendment is issued for individual conversion.

Deleted: 1. . The entity name appears within variable brackets so that it can be updated in the event of an approved name change.¶

¶
2. . The word "STATE" appears within variable brackets so that upon issue the name of the filing state will be included.¶

¶
Variable phrases and section references throughout such as "grievance", "Utilization Review and Grievance Procedure" and "Claim Procedures, Complaints and Appeals, External Review and Dispute Resolution" will be revised to reflect the terminology of the Contract Holder's plan.¶

¶
4. . Level Two – All references to Level Two appeals will included or omitted based on the Contract Holder's plan.¶

¶
4. . The Concurrent Care Claim Reduction or Termination continuation provision may be duplicated under other parts of the Appeal process in accordance with the final HHS regulation. The phrase "and Deductible" will be included if a Contract Holder's plan includes a deductible feature.¶

57. . Aetna may incur the entire cost of the External Review (*see the second to the last paragraph*) in the External Review section.¶

¶
6. . External Review – When external review is triggered by a claim denial due to a determination that the care is not medically necessary or is experimental or investigation then.¶

- . The language in the first paragraph beginning with "because HMO determines that..." will appear.¶

- . In the second bulleted item of the third paragraph, the optional language "of the denial of a claim" will appear.¶

- . The third bulleted item of the third paragraph will appear.¶

When external review is triggered by the broader coverage determination standard, the three items mentioned above will not appear, and the words "any of" will appear in the first sentence of the third paragraph.¶