Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(GR-GrpAppealsER-02)*

Policyholder:	State of Alaska
Group Policy No.:	GP-392675
Rider:	Alaska Complaint and Appeals Health Rider - Medical and Pharmacy
Issue Date:	October 1, 2011
Effective Date:	This Booklet-Certificate Amendment is effective on July 1, 2011

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.
- 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**.

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 or Booklet-Certificate.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

"Clean claim" means a claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment of the claim.

Complaint: Any 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) that is Federally approved made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

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

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

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

- seriously jeopardize your life or health;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

As to medical and **prescription drug** claims, **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

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**.

Urgent Care Claims

Aetna will notify you of an **urgent care** claim decision as soon as possible, but not later than 24 hours after the claim is made.

If more information is needed to make an urgent claim decision, **Aetna** will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 24 hours of the earlier to occur:

- the receipt of the additional information; or
- the end of the 24 hour period given the **physician** to provide **Aetna** with the information.

If the claimant fails to follow plan procedures for filing a claim, **Aetna** will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 72 hours after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 72 hour claim decision period is required. Such an extension, of not longer than 72 hour, will be allowed if **Aetna** notifies you within the first 72 hour 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 within 30 calendar days from the date your claim is received by **Aetna**. Your claim will fall into one of the following categories:

a. Your claim will be paid within 30 days from the date of **Aetna**'s receipt.
b. Your claim will be denied based upon the specific reasons outlined in a notice.
c. **Aetna** needs additional information as identified in a notice in order to process your claim. **Aetna** must pay the claim on the later of the following:

   - Within 15 days after receiving the specified information in the notice; or
   - Within 30 days from receiving the claim.

If **Aetna** does not provide you with the notice describe in items (b) and (c) above, the claim is assumed to be a **clean claim** and interest, for those covered expenses only, shall accrue at a rate of 15 percent annually beginning on the day following the day that the notice was due and continues to accrue until the date that the claim is paid.

Aetna will not retroactively deny a claim for certified care or treatment unless it is determined that the certification is based on materially incomplete or inaccurate information provided by the **physician** or other health care professional.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **emergency** or **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must 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 of **appeal** depending upon the type of coverage provided under the Plan. A **final adverse benefit determination** notice will also provide an option to request an **External Review.**

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- The Employer'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.

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

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

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by an **Aetna** employee or agent who holds the same professional license as the health care provider who is treating you. 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 18 calendar days of receipt of the request for an **appeal**.]

Exhaustion of Process

You must exhaust the applicable Level One processes of the Appeal Procedure before you:

- Contact the Alaska Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Alaska 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.

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:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above.

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination** because it determines that:

- the care is not **necessary**; or
- a service, supply or treatment is **experimental or investigational** in nature.

In either 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 **Aetna,** which will consist of **physicians** or other appropriate health care providers. The designated ERO will have expertise in the problem or question involved.

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision.

To request an **External Review**, the following requirements must be met:

- You have received notice of the denial of a claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or was **experimental or investigational**.
- You have exhausted the applicable internal **appeal** processes or you qualify for a faster review as explained below.

The claim denial letter you receive from **Aetna** will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to **Aetna** within 60 calendar days of the date you received the **adverse benefit determination** or **final adverse benefit determination** notice You also must include a copy of the notice and all other pertinent information that supports your request.

Aetna will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow **Aetna's** contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO within 21 working 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 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 must abide by the decision of the ERO unless you or **Aetna** file suit in superior court within 6 months from the date of the decision.

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.

For more information about the External Review process, 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)