Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment (GR-GrpAppealsER 03)
Policyholder:
Group Policy No.: GP-
Effective Date: This Amendment is effective on the later of:
July 12, 2012; or
The date you become covered under the Policy.

This document is not the official amendment to your Certificate of Insurance. It is a generic version of your official amendment. Your official amendment is the same as the generic version with the following information filled in: (1) the Policyholder's name, (2) your Group Policy Number and (3) the exact effective date that this change applies to your plan of benefits. You can obtain the official amendment from your Employer.

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 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, including determinations that **Aetna's** requirements for health care setting, level of care, appropriateness, or effectiveness are not met.
- A decision that the service or supply is **experimental or investigational**.
- A decision that the service or supply is not **medically necessary**.
- A decision that a preexisting condition was present prior to your effective date of coverage.

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

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.

Concurrent Care Review: A review conducted during a covered person's stay or course of treatment in a facility, the office of the health care professional, or other inpatient or outpatient health care setting.

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 Director of the Illinois Department of Insurance 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

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 72 hours after the claim is made.

If more information is needed to make an **urgent 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 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**.

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 two levels of **appeal**. A **final adverse benefit determination** notice will also provide an option to request an **External Review** (if available).

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 **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 Health Appeal

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**.

Exhaustion of Process

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

- Contact the Illinois Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Illinois 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;**
- Situations where you are receiving an ongoing course of treatment;
- Situations where you or your authorized representative file an internal **appeal** of an **adverse benefit determination** that involves a **concurrent care** or **Pre-Service Claim** review and have not received a written decision on that **appeal** 30 days following the date you or your authorized representative file that **appeal**;
- Situations where you or your authorized representative file an internal appeal of an **adverse benefit determination** that involves a **Post-Service Claim** review and have not received a written decision on that appeal 60 days following the date you or your authorized representative file that appeal; and
- Situations where you or your authorized representative file an expedited internal review of an **adverse benefit determination** and do not receive a decision on the request within 48 hours, except if you or your authorized representative agree to the delay.

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 and Illinois state law, 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

Aetna may deny a claim and you may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- Health care setting, level of care, or effectiveness requirements are not met;

- A preexisting condition was present before the effective date of coverage;
- Coverage has been rescinded due to a cancellation or discontinuance of coverage not due to a failure to timely pay required premiums;
- The care is not **medically necessary** or appropriate; or
- A service, supply or treatment is **experimental or investigational** in nature.

In these situations, you may submit a request for an **External Review** in writing to the Director of the Illinois Department of Insurance within 4 months after the date of your receipt of an **adverse benefit determination** or **final adverse benefit determination**, if you or your **provider** disagrees with **Aetna's** decision.

The address and toll-free telephone number of the Office of Consumer Health Information within the Illinois Department of Insurance is:

320 West Washington Street, 4th Floor
Springfield, Illinois 62767
(877) 527-9431
(E-mail): http://insurance.illinois.gov/Complaints/file_complaint.asp

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow in detail if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review* form. Some of these processes are included below.

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.
- You qualify for a faster review as explained below.
- You have exhausted the applicable internal **appeal** processes.
- 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 $500.

Within one business day after the date of receipt of an **External Review** request, the Director of the Illinois Insurance Department will send a copy of the request to **Aetna**.

Within one business day after completion of a preliminary review of your **External Review** request, **Aetna** will notify the Director of the Illinois Department of Insurance, you, and if applicable, your authorized representative in writing whether or not your request is complete and eligible for external review.

If your **External Review** request is not complete, **Aetna** will notify the Director of the Illinois Department of Insurance, you, and if applicable, your authorized representative in writing and include the information or materials that are required by Illinois law in order to make your **External Request** complete.

If your **External Review** request is not eligible for **External Review**, **Aetna** will notify the Director of the Illinois Department of Insurance, you, and if applicable, your authorized representative in writing and include the reason(s) for your request's ineligibility.

Whenever the Director of the Illinois Insurance Department receives notice that an **External Review** request is eligible for **External Review** following the preliminary review, within one business day following the date of receipt of the notice, the Director will assign an External Review Organization (ERO) and notify **Aetna** of the name of the ERO. The Director of the Illinois Department of Insurance will also notify you,

and if applicable, your authorized representative in writing of the request's eligibility and acceptance for **External Review**, including the name of the ERO.

Upon receipt of the information and documents from **Aetna**, and any other information you, and if applicable, your authorized representative submits in writing to the ERO, the ERO will review.

Within one business day after the receipt of any information you, and if applicable, your authorized representative submit, the ERO will forward the information to **Aetna**. **Aetna** may reconsider its **adverse benefit determination** or **final adverse benefit determination** that is the subject of the **External Review**.

If **Aetna** decides to reverse its **adverse benefit determination** or **final adverse benefit determination**, within one business day after making that decision, **Aetna** will provide a written notice to the Director of the Illinois Insurance Department, you, and if applicable, your authorized representative of the decision. The ERO will terminate the **External Review** following receipt of notice from **Aetna** of the decision to reverse its **adverse benefit determination** or **final adverse benefit determination**.

If **Aetna** does not reverse its **adverse benefit determination** or **final adverse benefit determination**, within 5 days after the date of receipt of all necessary information, but not later than 45 days after the date of the receipt of the **External Review** request, the ERO will provide written notice of its decision to either uphold or reverse the **adverse benefit determination** or **final adverse benefit determination** to the Director of the Illinois Insurance Department**, Aetna**, and you, and if applicable, your authorized representative.

A faster review of your **adverse benefit determination** by an ERO is possible if you or your **physician** certifies (by telephone or on a separate *Request for External Review* form) to the Director of the Illinois Insurance Department 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 **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 by the ERO, as expeditiously as the covered person's medical condition or circumstance requires, but within 72 hours of the receipt of all pertinent information. Within this time frame, the ERO will notify the Director of the Illinois Insurance Department, **Aetna**, you, your health care provider, and if applicable, your authorized representative of the decision. If this faster review decision was not communicated in writing by the ERO, then within 48 hours of the date of that notice, the ERO will provide written confirmation of its decision to the Director of the Illinois Insurance Department, **Aetna**, you, and if applicable, your authorized representative.

Aetna will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

If an ERO performing an **External Review** upholds a decision adverse to you, you, and if applicable, your authorized representative may appeal the decision to the Illinois Department of Insurance. The Director of the Illinois Department of Insurance may overturn the **External Review** 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** processes, call the **Member Services** telephone number shown on your ID card.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Rider: 1414N-IL
Illinois - HCR/Appeals
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