

# Aetna Life Insurance Company

Hartford, Connecticut 06156

**Amendment** *(GR-9N-Appeals 01-01 01)*

**Policyholder:** Choctaw Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Arizona Complaint and Appeals Health Rider  
**Issue Date:** March 31, 2010  
**Effective Date:** January 1, 2010

## Complaint and Appeals - Health Coverage

The group policy specified above has been amended. The following summarizes the changes in the group policy, and the Certificate of Insurance describing the policy terms is amended accordingly. This amendment is effective on the date shown above.

## Appeals Procedure

### Definitions

**Adverse Benefit Determination:** 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;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

**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 previously approved course of treatment.

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

**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:

- jeopardize your life;
- 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.

## **Claim Determinations** *(GR-9N-Appeals 01-02 01)*

### **Urgent Care Claims**

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, 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 48 hours of the earlier of the receipt of the additional information or the end of the 48 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 make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 15 calendar days claim determination 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 days period. If this extension is needed because Aetna needs additional information to make a claim determination, 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 make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination 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 additional information to make a claim determination, 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 make notification of a claim determination for **emergency** or **urgent care** as soon as possible but not later than 24 hours, with respect to **emergency** or **urgent care** provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 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 make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

## **Complaints** *(GR-9N-Appeals 01-05 01)*

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You 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 additional 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** *(GR-9N-Appeals 01-06 01-AZ)*

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. This Plan provides for two levels of **appeal**. It will also provide an option to request an external review of the **adverse benefit determination**.

You have two years following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an **adverse benefit determination**;
- Your reasons for making the **appeal**; and
- Any other information you would like to have considered.

Send in your **appeal** to Customer Service at the address shown on your ID Card, or call in your **appeal** to Customer Service using the toll-free telephone number shown on your ID Card.

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

### **Level One Appeal** *(GR-9N-Appeals 01-07 01-AZ)*

For Utilization Review

A level one **appeal** of an **adverse benefit determination** shall be provided by Aetna personnel not 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**.

#### **For Other Than Utilization Review**

A level one appeal of an Adverse Benefit Determination shall be provided by Aetna personnel not 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 an Appeal.

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

Aetna shall issue a decision within 15 calendar days of receipt of the request for an Appeal.

#### **Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for an Appeal.

### **Level Two Appeal (For Other Than Utilization Review)**

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the adverse determination 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 notice of a level one **appeal**.

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 not involved in making an **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 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** *(GR-9N-Appeals 01-10 01)*

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- contact the Arizona Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the Arizona 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.

### **External Review** *(GR-9N-Appeals 01-011 01-AZ)*

Aetna may deny a claim because it determines that the care is not appropriate or a service 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 **physician**, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not **necessary** or was **experimental or investigational**; and
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable internal **appeal** processes.

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 final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a **physician reviewer** 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 Independent Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

If the case involves an issue of medical necessity, the external reviewer shall forward to the independent reviewer(s) all of the following:

- All medical records and supporting documentation pertaining to your case;
- A summary description of the applicable issues including a statement of the review agent's decision;

- The criteria used and the clinical reasons for the decision;
- The relevant portions of the external reviewer's utilization review plan; Mail to the Director a summary description of the applicable issues including a statement of the utilization review agent's decision and any transmittal letter that is sent to the independent reviewer(s).
- If the case involves only an issue of coverage, the review agent shall mail to Aetna, the member and the physician a notice of the decision.

When you are denied a request for a covered service your physician may certify in writing that the time period for an informal reconsideration or formal appeal is likely to cause a negative change in the member's condition and that you may pursue an expedited appeal. The determination by your physician that delay may cause a negative impact on your condition is not open to challenge by Aetna.

When you decide to proceed with an expedited appeal, your physician must immediately submit a written appeal of the denial of the service to the utilization review agent and provide them with any additional material or documentation to support the your request. Within three business days after receiving the request for an expedited appeal, the utilization review agent must provide notice of their decision. If the issue is one of medical necessity, any provider, physician or other health care professional who is qualified licensed, employed or under contract with the utilization review agent and who is qualified in a similar scope of practice as a in state provider, physician or other health care professional or who typically manages the medical condition under appeal shall review the expedited appeal and render a decision.

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

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the Independent Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the Independent Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the toll-free Customer Services telephone number shown on your ID card.

A handwritten signature in black ink that reads "Ronald A. Williams". The signature is written in a cursive, flowing style.

Ronald A. Williams  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)