

# Aetna Life Insurance Company

Hartford, Connecticut 06156

**Amendment** *(GR-GrpAppealsER 02 AZ)*

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Arizona Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** This Booklet-Certificate Amendment is effective on January 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**.

**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.

**External Review:** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State Insurance Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

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

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

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

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

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

### **Full and Fair Review of Claim Determinations and Appeals**

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

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

### **Claim Determinations – Group Health Coverage**

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

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 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 **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 or two levels 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 2 years 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.
- Your 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 – Group Health Claims** **For Utilization Review**

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**.

### **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 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 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

**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 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.

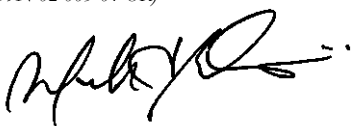
**Aetna** will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

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

*(GR-9N-02-005-01 OK)*



Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## **Amendment** *(GR-GrpAppealsER-02)*

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Louisiana Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** This Booklet-Certificate Amendment is effective on January 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**.

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

**Business Day:** Monday through Friday (excluding holidays and days upon which Aetna is unable to conduct business in a normal manner due to an emergency situation declared by state or local government authorities).

**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) assigned by the State Insurance Commissioner, 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 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 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.

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 a claim determination as soon as possible, but not later than 2 business days after a pre-service claim request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will provide written confirmation of such notification within 2 business days of making the claim determination.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event, will the extension period exceed 30 business days from the date of the pre-service claim request unless you or the provider has agreed to the extension period.

## Post-Service Claims

Aetna will make a claim determination as soon as possible, but not later than 30 business days after a post-service claim request, provided that Aetna has received all appropriate medical information. Aetna will make notification of a claim determination to the provider rendering the service not later than 5 business days after the claim determination is made.

If an extension is required because Aetna needs additional information to make a claim determination, the covered person will receive a notice of the extension. The notice shall specifically describe the required information. In no event, will the extension period exceed 180 calendar days from the date of the post-service claim request.

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

- coverage was terminated due to fraud or non-payment of premiums; or
- the approval was based upon a material omission or misrepresentation of the person's health condition by the provider.

## Concurrent Care Claim Extension

In the case of a concurrent claim extension request approval, Aetna will provide notification of a claim determination to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will make written confirmation of such notification within 2 business days after the claim determination.

In the case of an adverse benefit determination, Aetna will provide notification to the provider rendering the service not later than 1 business day after the claim determination has been made. Aetna will make written confirmation of such notification within 1 business day of providing notification. The service or supply will be continued without liability to the provider or the person (subject to the terms of the Policy) until the provider receives notice of Aetna's decision.

## Concurrent Care Claim Reduction or Termination

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

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

## ***Complaints***

If you are dissatisfied with the service you receive from the Plan or want to complain about an **network provider** you must write Member Services within 30 calendar days of the incident. 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***

### **Informal Process**

As to an adverse benefit determination involving a group health claim, the provider rendering the service that was denied may request, on your behalf and within 10 calendar days following the date of the notice of the adverse benefit determination, an informal reconsideration of the claim determination. The informal reconsideration will be completed within 1 business day of Aetna receiving the request from the provider and will be conducted between the provider and the Aetna Medical Director involved in making the adverse benefit determination. If the Medical Director is not available then the Medical Director may designate a clinical peer in his or her place.

In the event that the informal reconsideration does not resolve the differences of opinion to your satisfaction, then the adverse benefit determination may be appealed as described below in the Formal Process.

### **Formal Process**

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. This Plan provides for one level or two levels of **appeal** depending upon the type of coverage provided under the Plan. As to medical and **prescription drug** claims only, a **final adverse benefit determination** notice 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.
- Your 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**.

As to medical and **prescription drug** claims only, you may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

### ***Level One Appeal – Group Health Claims***

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

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

**Aetna** shall issue a written decision within 72 hours of receipt of the request for an **appeal**.

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

Aetna shall issue a written decision within 15 business days of receipt of the request for an **appeal**.

**Post-Service Claims**

Aetna shall issue a decision within 30 business days of receipt of the request for an **appeal**.

A duly licensed **physician** must concur with any Adverse Benefit Determination that is upheld. The contents of the written decision will comply with any applicable state law.

***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**.

To request a Level Two Appeal for an **adverse determination** that is based on **experimental or investigational** reasons you must meet the eligibility requirements of any applicable Louisiana statute or regulation.

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**.

The Level Two Appeal review will occur within 45 days of Aetna receiving a request for a Level Two Appeal. You have the right to attend the Level Two Appeal review and will be notified of your rights at least 15 business days in advance of the date of the review. The contents of the notice will comply with any applicable state law. If you cannot attend the review, you may participate by conference call or other available technology. You may also request that Aetna consider postponement and re-scheduling of the hearing.

If requested, Aetna will provide you with all relevant information regarding your Appeal that is not confidential or privileged.

The Aetna Level Two Appeal committee will render its decision or recommendation in accordance with any applicable Louisiana statute or regulation.

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

Aetna shall issue a written decision within 72 hours of conclusion of the Level Two **Appeal** review.

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

Aetna shall issue a written decision within 5 business days of the date of the Level Two **Appeal** review.

**Post-Service Claims**

Aetna shall issue a written decision within 5 business days of the date of the Level Two **Appeal** review.

A duly licensed and appropriate clinical peer must concur with any Adverse Benefit Determination that is upheld. The contents of the written decision will comply with any applicable state law including information on your right to request an External Review.

## Exhaustion of Process

Aetna encourages you to exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Louisiana Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Louisiana Department of Insurance; or
- Establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

As to medical and **prescription drug** claims only, under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes--these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

### **Important Note:**

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

### **External Review**

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
- As to an **adverse determination** that is based on **experimental or investigational**, the cost of the service or treatment in question for which you are responsible exceeds \$500;
- As to all other **adverse determinations**, the cost of the service or treatment in question for which you are responsible exceeds \$1,000;
- You have exhausted the applicable internal **appeal** processes; and
- You meet the eligibility requirements for external review of any applicable Louisiana statute or regulation.

You do not have to exhaust the internal Appeals Procedure to request an external review if:

- Aetna agrees to waive the internal Appeals Procedure for the Level One, Level Two Appeal or both; or
- your treating **physician** has certified in writing that you have an **emergency condition**.

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.

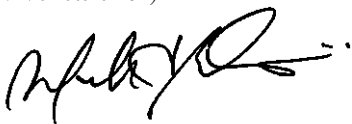
Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible 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 External 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 service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

The External Review Organization will render its decision or recommendation in accordance with any applicable Louisiana statute or regulation. Aetna will abide by the decision of the External Review Organization, 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 External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review. For more information about the External Review process, call the toll-free Customer Services telephone number shown on your ID card.

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

*(GR-9N-02-005-01 OK)*

A handwritten signature in black ink, appearing to read 'Mark T. Bertolini', with a stylized flourish at the end.

Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

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

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Mississippi Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** January 1, 2011

## **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)*

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 180 calendar days 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)*

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**.

### **Level Two Appeal**

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 your state's Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the your state's 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 01-11 01)*

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.

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.

(GR-9N-02-005-01 OK)

A handwritten signature in black ink, appearing to read 'Mark T. Bertolini', with a stylized flourish at the end.

Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

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

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Oklahoma Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** January 1, 2011

## 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)*

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 180 calendar days 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 OK)*

#### **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**.

### **External Review** *(GR-9N-Appeals 01-11 01)*

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.

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.

(GR-9N-02-005-01 OK)

A handwritten signature in black ink, appearing to read 'Mark T. Bertolini', with a stylized flourish at the end.

Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## **Amendment** *(GR-Grp,AppealsER02)*

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Texas Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** This Booklet-Certificate Amendment is effective on January 1, 2011

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.

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, among other things:

- The 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; or
- A decision that the service or supply is not **Medically Necessary**.

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

**Claim Subject to Preauthorization:** Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

**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 previously approved course of treatment.

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

**Post-Service Claim:** Any claim that is not a “**Claim Subject to Preauthorization**.”

**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 benefit 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 the treating **physician** or other health care provider within one hour of notification of the request.

For other **urgent care claims**, Aetna will make notification by telephone or electronic transmission of a claim decision as soon as possible but not more than one working day after the claim is made. Written notification will be made within three working days.

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 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.

### **Claims Subject to Preauthorization**

Aetna will make written notification of a decision concerning a **claim subject to preauthorization** within the time appropriate to the circumstances relating to the delivery of the services but not more than two working days after the claim is made.

If it is an **adverse benefit determination** Aetna will send notice of that determination accompanied by the following:

- (1) the principal reasons for the **adverse benefit determination**;
- (2) the clinical basis for the **adverse benefit determination**;
- (3) a description of or the source of the criteria used as the guideline in making the adverse benefit determination; and
- (4) a description of the procedure for the appeal process, including notice of the covered person's right to appeal an adverse benefit determination to an External independent review organization and of the procedures to obtain that review.

## Concurrent Care Claim Extensions, Reductions or Terminations

If a covered person is hospitalized at the time of a request for a Concurrent Care Claim Extension, Aetna will make notification by telephone or electronic transmission of a claim decision of regarding concurrent care claim extension as soon as possible but not more than one working day after the claim is made. Written notification will be made within two working days.

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.

## Post-service Claims

Aetna will make notification of a post-service claim decision 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 the covered person 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.

## Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you, or the person you authorize to do so must write Aetna Customer Service. 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

You may submit an Appeal if Aetna gives notice of an **adverse benefit determination**. It will also provide an option to request an external review of the **adverse benefit determination**. If you choose, another person (an authorized representative) may make the appeal on your behalf by providing written consent to **Aetna**.

Your appeal must 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.

Aetna will acknowledge receipt, in writing, of your appeal within 5 working days of receiving it.

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.

## Group Health Claims

The review of an appeal of an **adverse benefit determination** shall be provided by an Aetna physician not involved in making the **adverse benefit determination**.

## **Non-Expedited Appeals** (Applies for Claims Subject to Preauthorization and Post-Service Claims)

### **Claims Subject to Preauthorization** (May Include Concurrent Care Claim Reduction or Termination)

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

If an **adverse benefit determination** concerning specialty care is upheld upon appeal, the health care provider has 10 working days in which to request, in writing, a specialty review. The **adverse benefit determination** will be reviewed by a provider in the same or similar specialty as that which is the subject of the **adverse benefit determination** and the review will be complete within 15 working days of its receipt of the request.

### **Post-Service Claims**

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

## **Expedited Appeals** (Applies for Urgent Care Claims -- May Include Appeals Regarding Concurrent Care Claim Reductions or Terminations of Hospital Stays)

Aetna shall issue a decision on the appeal of an **adverse benefit determination** for an Urgent Care Claim within a timeframe consistent with the urgency of the condition, procedure or treatment, but in no event in a timeframe exceeding the earlier of 1 working day from the date all information necessary to complete the Appeal has been received by Aetna. If Aetna has provided notice of the decision orally, written notice of the decision will be provided within three calendar days of the oral notification.

If yours is a life-threatening **Urgent Care Claim**, you may immediately appeal Aetna's **adverse benefit determination** to an independent External Review Organization. You are not required to first comply with Aetna's appeals process. Please see the section entitled "External Independent Review", below.

## **External Independent Review**

If Aetna has denied a claim for benefits, you may request an external review of your claim if you or your provider disagrees with Aetna's decision. An external review is a review by an independent **physician**, selected by an independent External Review Organization, who has expertise in the problem or question involved. You may request a review by an independent External Review Organization assigned to the appeal by the Texas Department of Insurance for any appeal related to an **adverse benefit determination** concerning a claim subject to preauthorization involving a decision that the service, supply, or non-formulary drug is not **medically necessary**.

If your **adverse benefit determination** is for an Urgent Care Claim involving a life-threatening condition, you have the right to have your claim immediately reviewed by an independent External Review Organization. You are not required to exhaust Aetna's internal appeals 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.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** 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.

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 service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the External Review Organization.

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

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

## **Exhaustion of Process**

Unless otherwise noted above, you must exhaust the applicable processes of the Appeal Procedure before taking further action.

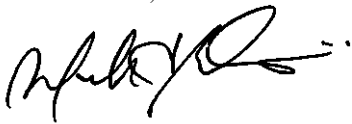
You may not:

- contact the Texas Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with the Texas 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:

- (1) before the 61st day after the date written proof of loss is filed as required under the policy; or
- (2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed.

*(GR-9N-02-005-01 OK)*



Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

# Aetna Life Insurance Company

Hartford, Connecticut 06156

## Amendment

**Policyholder:** Choctaw Archiving Enterprises  
**Group Policy No.:** GP-819977  
**Rider:** Complaint and Appeals Health Rider  
**Issue Date:** April 25, 2011  
**Effective Date:** January 1, 2011

## 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. This amendment applies to members who reside in a state other than Arizona, Louisiana, Maine, Mississippi, Oklahoma, Rhode Island, Texas or Washington but who are covered under a group policy issued in Arizona, Louisiana, Maine, Mississippi, Oklahoma, Rhode Island, Texas or Washington.

## 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:** An oral or written request to Aetna to reconsider an **adverse benefit determination**.

**Complaint:** Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a 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 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 15 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. 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 01-050 01)*

If you are dissatisfied with the service you receive from the Plan or want to complain about a **provider** you must call or 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)*

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 180 calendar days following the receipt of notice of an **adverse benefit determination** to request your level one **appeal**. Your **appeal** may be submitted orally or 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)*

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.

### **Level Two Appeal**

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 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 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 01-11 01)*

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you 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 01-10 01)*

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.

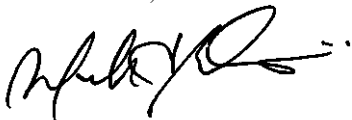
Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent **physician** with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible 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 External 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 service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna will abide by the decision of the External Review Organization, 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 External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

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

*(GR-9N-02-005-01 OK)*



Mark T. Bertolini  
Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)

