

# Aetna Life Insurance Company

Hartford, Connecticut 06156

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

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

## Complaint and Appeals - Health Coverage

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

## Appeals Procedure

### Definitions

**Adverse Benefit Determination:** A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

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

**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 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 LA)*

### **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 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**

Aetna will make a claim determination as soon as possible, but not later than 1 **business day** after a **concurrent care claim extension** request, provided that Aetna has received all appropriate medical information.

In the case of a **concurrent care 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 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 LA)*

#### **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 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 LA)*

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 **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 an **adverse benefit determination** that is upheld. The contents of the written decision will comply with any applicable state law.

### **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** shall be provided by Aetna personnel not involved in making an **adverse benefit determination**. A level two **appeal** of an **adverse benefit determination** of a **pre-service claim** or a **post-service claim** will be reviewed by the Aetna Appeals Committee.

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.

### **Urgent Care Claims** (May Include **concurrent care claim reduction or termination**)

Aetna shall issue a decision within 36 hours of receipt of the conclusion of the Level Two **appeal** review.

### **Pre-Service Claims** (May Include **concurrent care claim reduction or termination**)

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

### **Post-Service Claims**

Aetna shall issue a 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** *(GR-9N-Appeals 01-10 01 LA)*

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 Life Insurance Company; or any matter within the scope of the Appeals Procedure.

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

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.

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

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

Ronald A. Williams  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company  
(A Stock Company)