

Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment *(Appeals01)*

Policyholder: Choctaw Enterprises
Group Policy No.: GP-819977
Rider: Texas 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.

Complaint and 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, or supply or benefit.

Such **adverse benefit determination** may be based on, among other things:

- 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.

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 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.

Adverse Benefit Determinations

Urgent Care Claims

In the case of an **adverse benefit determination** for post-stabilization care following emergency treatment, 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 an **adverse benefit determination** 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 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 written notification of an **adverse benefit determination** within the time appropriate to the circumstance relating to delivery of the services but not more than three working days after the claim is made.

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 an **adverse benefit determination** of a 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 three working days.

Post-Service Claims

Aetna will make notification of an **adverse benefit 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.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if Aetna gives notice of an **adverse benefit determination**. You also have 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** 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.

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

Group Health Claims

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

Standard Appeals

(Applies for both Pre-Service and Post-Service Claims)

Pre-Service claims (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 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 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 a pre-service **adverse benefit determination** involving a determination 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.

For other than life threatening situations, 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.

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.

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)