

Aetna Life Insurance Company

Hartford, Connecticut 06156

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

Policyholder: State of Alaska
Group Policy No.: GP-392675
Rider: Alaska Complaint and Appeals Health Rider - Dental,
Vision and Hearing
Issue Date: October 1, 2011
Effective Date: July 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 03-AK)*

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 24 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 24 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 within 72 hours after the pre-service claim is made. Aetna may determine that due to matters beyond its control an extension of this 72 hour claim determination period is required. Such an extension, of not longer than 72 hours, will be allowed if Aetna notifies you within the first 72 hour 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.

Aetna will not retroactively deny a claim for preauthorized care or treatment unless it is determined that the preauthorization is based on materially incomplete or inaccurate information provided by the physician or other health care professional.

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 03-AK)

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 18 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 at least two **Physicians** or other health care professionals who hold the same professional license as the health care provider who is treating the Member and who are 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 18 calendar days of receipt of the request for a level two **appeal**.

Exhaustion of Process *(GR-9N-Appeals 01-10 01 AK)*

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

- contact Alaska Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- file a complaint or **appeal** with the Alaska'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 02 AK)*

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 or as soon as reasonably possible. 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 21 working 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 72 hours after Aetna receives the request.

A decision of an external **appeal** agency is binding unless the person, who is aggrieved by a final decision of an external **appeal** agency, appeals the decision to the superior court within six months of the external **appeal** agency decision.

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

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

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

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

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)