



1000 Middle Street  
Middletown, CT 06457  
**Grace Lewicki**  
Client Svcs Support Consultant

July 2009

Subject: New York Senate Bill 3986 - Complaints and Appeals - Health Coverage

To Our Valued Customer:

The following revision applies to group policies providing Health coverage issued by Aetna Life Insurance Company in New York.

The purpose of this Certificate Amendment is to define an out-of-network denial for plans that use a provider network and has been added to the Complaints and Appeals section of the Booklet-Certificate:

This law is effective for new and existing cases on April 1, 2008.

In addition, this certificate amendment should not be distributed to members of your plan who reside in Arizona, Louisiana, Maine, Mississippi, Oklahoma, Texas, and Washington.

There are two attachments to this email:

- A copy of a Certificate Amendment issued in response to this law. You should distribute this to your employees who are affected by the law and are covered by one of the policies mentioned above, or arrange for it to be viewable on your company website if that's where you house your existing certificates.
- A copy of a Policy Rider to your Group Insurance Policy. The Policy Rider should be filed into your policy.

Please note that both the Policy Rider and the Certificate Amendment are general documents. Documents specific to your plan will be issued to replace the generic form at the next regular plan revision, or upon request.

If you have any questions about this law, please contact your Aetna Account Representative.

Sincerely,

A handwritten signature in cursive script that reads "Grace Lewicki".

Grace Lewicki  
Client Services Support Consultant

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Policyholder No. 619383

# Rider

Attached to and made a part of Group Policy No. GP-619383

a contract between

## **Aetna Life Insurance Company**

and the Policyholder

## **METAL LATHERS LOCAL 46 TRUST**

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It is understood and agreed that the policy is changed by the addition or deletion of the pages listed below.

Page Numbers Of Pages Added

Page Numbers Of Pages Deleted

9010 - NY SB 3986 4 1 08

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Nothing contained in this rider shall be held to alter or affect any of the terms of the policy other than as herein specifically stated.

**In Witness Whereof**, the **Aetna Life Insurance Company** has signed this rider at **Hartford, Connecticut**, to become effective April 1, 2008.

Signed by the Insurance Company July 10, 2009.



**Ronald A. Williams**  
**Chairman, Chief Executive Officer, and President**

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# Policy Contents

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This policy consists of:

The Face Page, Index, this Policy Contents page, and all the provisions of Parts I and II; and

The provisions found in the Certificate(s) listed in this section.

The words "you" or "your" in any Certificate included in this policy, will refer to a covered Employee.

The Certificate(s) included in this policy are as follows:

A "Certificate" consists of a Certificate Base document ("Cert. Base") and any Summary of Coverage ("SOC") or Certificate Amendment ("Rider") which may be issued to support or amend the Cert. Base.

<b>Identification</b>	<b>Issue Date</b>	<b>Effective Date</b>
Rider-1037	July 10, 2009	April 1, 2008

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# Aetna Life Insurance Company

Hartford, Connecticut 06156

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Amendment

**Policyholder:** METAL LATHERS LOCAL 46 TRUST

**Group Policy No.:** GP- 619383

This Certificate Amendment describes a change in your Certificate, which applies to group policies providing health coverage issued by Aetna Life Insurance Company in the State of New York.

The purpose of this Certificate Amendment is to add this provision to your Certificate if it is not already included or to replace a corresponding provision which is included but which provides a lesser benefit or coverage.

Keep this Certificate Amendment with your Certificate at all times.

This Certificate Amendment is effective on the later of the date you become covered under the group policy and April 1, 2008.

Please note, this Certificate Amendment does not apply to members who reside in Arizona, Louisiana, Maine, Mississippi, Oklahoma, Texas, and Washington.

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Language that follows replaces existing language in the Appeals Procedure section of your Booklet-Certificate.

## *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 because it is determined to be experimental or investigational or not medically necessary or appropriate.

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

Your eligibility for coverage;

The results of any Utilization Review activities (determination as to whether or not an admission, extension of stay, or other health care service or supply is **medically necessary**, based on the information provided).

If applicable, denials of out-of-network claims on the basis that an out-of-network service is not materially different than an in-network service shall not constitute an **adverse benefit determination**.

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

**Health care provider:** A health care professional or facility licensed pursuant to New York law or licensed, registered or certified by another state.

**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 or provide additional services.

**Expedited Appeal:** Appeal of an **adverse benefit determination** involving (1) continued or extended health care services, procedures and treatments or additional services for a covered person undergoing a course of continued treatment prescribed by a health care provider, or (2) an **adverse benefit determination** in which the health care provider believes an immediate appeal is warranted where there is imminent or serious threat to the health of the insured, except any retrospective determination.

**Grievance:** A request for review of a determination, other than a determination meeting the definition of **adverse benefit determination**.

**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 "Concurrent Care Claim Extension," an "Urgent Care Claim" or a "Pre-Service Claim."

**Urgent Care Claim:** Any claim for medical care or treatment with respect to which a delay: (a) could seriously jeopardize the life or health of the person or the ability of the person to regain maximum function; or (b) in the opinion of a physician with knowledge of the person's medical condition would subject the person to severe pain that cannot be adequately managed without the requested treatment.

**Out-of-Network Denial:** A denial of a request for preauthorization to receive a health service from an out-of-network provider on the basis that such service is not materially different from a health service available in-network. The Notice of denial of such out-of-network service shall include information explaining what information must be submitted to appeal the denial.

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

### **Urgent Care Claims**

Aetna will make notification of a claim determination as soon as possible, but not later than 72 hours after receipt of the necessary information.

### **Pre-Service Claims**

Aetna will make notification of a claim determination as soon as possible but not later than 3 business days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days. Aetna will notify you or your designee and your **Health Care Provider** of the determination by

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telephone and in writing. Notification will include the total of approved services, the date of the onset of services and the next review date.

### **Concurrent Care Claim Extension**

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination by telephone and in writing to you, your designee and your **health care provider** as soon as possible, but no later than 24 hours after receipt of the necessary information.

### **Post-service Claims**

Aetna will make notification of a claim determination in writing as soon as possible but not later than 30 calendar days after receipt of the necessary information. In the event you fail to provide all of the necessary information for Aetna to make a claim determination, Aetna will allow you 45 days to submit the necessary information, and will make a claim determination within 15 days after receipt of such information. If the information requested is not received by Aetna after 45 days, Aetna will make a determination based on information available and will notify you of the decision within 15 days.

The Notice of **adverse benefit determination** will include:

- The reasons for the **adverse benefit determination**, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any;
- A description of the plan's review procedures, including a statement of claimants' rights to bring a civil action
- Instructions on how to start the appeals, expedited appeals and external appeals process;
- Notice of the availability, upon request, of the clinical review criteria used to make the **adverse benefit determination**. This notice will also specify what necessary additional information, if any, must be provided to, or obtained by, Aetna in order to render a decision on **appeal**.

In the event that Aetna renders an **adverse benefit determination** without first attempting to discuss the matter with the insured's **health care provider** who specifically recommended the service, procedure or treatment, the **health care provider** will have the opportunity to request a reconsideration of the adverse benefit determination. Except for post-service claims, such reconsideration will occur within one business day of receipt by Aetna of the request. If the **adverse benefit determination** is upheld, Aetna will provide notice, as described above.

If Aetna does not render a decision within the period set forth above, you may consider this to be an **adverse benefit determination**, subject to **appeal**.

### ***Complaints***

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 15 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.

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You may also submit an oral **complaint** in connection with:

- A denial or failure to pay for, a referral;
- A determination as to whether a service is covered under the Plan;

By calling Customer Service. Aetna's Customer Service telephone number is on your ID card. If you are required to leave a recorded message, your message will be acknowledged within one business day after the call was recorded.

Aetna will summarize the nature of the complaint in writing. You will be required to sign a written acknowledgement of the **complaint**. You must sign and return the acknowledgement, with any amendments, in order to initiate the **complaint**. An acknowledgement letter will be sent to you within 15 days of Aetna's receipt of the **complaint**. This letter may request additional information. If so, the additional information must be submitted to Aetna within 15 days of the date of the letter.

### ***Appeals of Out-of-Network Denials (if applicable)***

You may appeal an out-of-network denial based on the fact that an alternate service is available in-network by submitting:

- a written statement from your **physician** that the service is materially different from the health service the plan approved to treat your medical needs
- two documents from available medical and scientific evidence, stating that such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased.

### ***Appeals of Adverse Benefit Determinations***

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**.

With respect to Group Health Claims, 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. The request should include:

- Your name;
- Your employer's name;
- A statement from your physician;
- 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 an authorized designee make the **appeal** on your behalf by providing written consent to Aetna. Your **health care provider** may make the appeal in connection with the **adverse benefit determination** for a **post service claim**.

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

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

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## **Expedited Appeals**

Aetna has established an expedited **appeals** process for adverse **benefit determinations** involving **urgent care** claims, **concurrent care claim extensions** and **pre-service claims**. Aetna will render a decision involving **urgent care, concurrent claim extension** and **pre-service claims** within 36 hours of receipt of the necessary information to conduct the **appeal**.

## **Standard Appeals**

Aetna shall issue a decision within 30 calendar days of receipt of the necessary information to conduct the **appeal**. Aetna will provide written acknowledgement of the filing of the **appeal** within 15 days of its receipt.

The notice of the appeal determination will include:

- If the **adverse benefit determination** is upheld, the reason for the determination, including the clinical rationale for it; and
- A notice of your right to an external appeal, together with information and a description of the external **appeals** process. You also have the option to request a Level 2 **appeal** from Aetna.

If Aetna does not render an appeals determination within 60 days after receipt of the information necessary to conduct the appeal, the adverse benefit determination will be reversed.

## ***Level Two Appeal (applies only to Group Health Claims)***

If Aetna upholds an **adverse benefit determination** at the first level of **appeal**, you or your authorized representative have the option to file a level two **appeal** or request an External Appeal. The Level Two **appeal**, if requested, must be submitted within 60 calendar days following the receipt of notice of a level one **appeal** determination.

A level two **appeal** of an **adverse benefit determination** of an **expedited appeal** shall be provided by Aetna personnel not involved in making the **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.

## **Expedited Appeals (Urgent Care Claims, Concurrent Care Claims Extensions and Pre-Service Claims)**

Aetna shall issue a decision within 36 hours of receipt of the request for a level two **appeal** for these claims.

### **Pre-Service Claims** (other than those subject to an Expedited Appeal)

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**.

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## ***Grievances - Applies only to Group Health Claims***

You may submit a **grievance** to Aetna with respect to review of any determination other than an **adverse benefit determination**.

Aetna will acknowledge receipt of the **grievance** within 15 calendar days after its receipt by Aetna.

### **Grievance Determinations**

#### Expedited Grievances

Aetna will resolve an expedited **grievance** within 36 hours after receipt of all necessary information when delay would significantly increase the risk to a person's health.

#### Standard Grievances

For other **grievances**, Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the **grievance**, but not later than 45 days after receipt of all necessary information.

### **Grievance Appeals**

#### Expedited Grievances

Aetna will render a decision within 36 hours after receipt of the appeal.

#### Standard Grievances

Aetna will acknowledge receipt within 15 calendar days and issue a determination within 30 calendar days after receipt of the appeal.

## ***External Review***

### **Your Right to an External Appeal**

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if Aetna has denied coverage on the basis that the a) service is not medically **necessary** or is an experimental or investigational treatment or (b) if applicable, such service is out-of network and an alternate is available in-network, you may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

### **Your Right to Appeal a Determination that a Service is not Medically Necessary**

If Aetna has denied coverage on the basis that the service is not medically **necessary**, you may **appeal** to an External Appeal Agent if you satisfy the following criteria listed below:

The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and

You must have received a final **adverse benefit determination** through the first level of Aetna's internal review process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

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The service must otherwise be a Covered Medical Expense under this plan; and

You must have received a final adverse benefit determination through the first level of Aetna's internal appeal process and Aetna must have upheld the denial or you and Aetna must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the attending physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or medical impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that the life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered under this plan or one for which there exists a clinical trial (as defined by law.)

In addition, your attending physician must have recommended at least one of the following:

A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in support of this recommendation – your attending physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or

A clinical trial for which you are eligible (only certain clinical trials can be considered).

### **Your Right to Appeal a Determination that an Alternate Service is available In-Network**

If Aetna has denied coverage on the basis that an alternate service is available in-network (other than a clinical trial, which is covered immediately above), you may appeal to an External Appeal Agent if you satisfy the following criteria listed below:

The service, procedure or treatment must otherwise be a Covered Medical Expense under this plan; and

You must have received a final adverse benefit determination through the first level of Aetna's internal review process and Aetna must have upheld the denial, or you and Aetna must agree in writing to waive any internal appeal; and

The attending physician certifies that such out-of-network service is (i) materially different than the alternate in-network service; and (ii) based on two documents from available medical and scientific evidence, such service is likely to be more clinically beneficial than the alternate in-network service and the adverse risk would not be substantially increased.

For the purposes of this section, your attending physician must be a licensed, board certified or board eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

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## The External Appeal Process

If, through the first level of Aetna's internal appeal process, you have received a final adverse benefit determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, or an alternate service is available in-network (if applicable), you have 45 days from receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal appeal, you have 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide an external appeal application with the final adverse benefit determination issued through the first level of Aetna's internal appeal process or its written waiver of an internal appeal.

You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. The completed application must be submitted to the New York State Department of Insurance at the address listed in the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Aetna based its denial, the External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If Aetna chooses to exercise this right, Aetna will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), Aetna does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within thirty (30) days of receipt of the completed application. The External Appeal Agent may request additional information from you, your physician or Aetna. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns Aetna's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or if applicable, determines that the out-of-network service should be covered under the Plan, Aetna will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is admissible in any court proceeding.

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## **Your Responsibilities**

It is your responsibility to initiate the external appeals process. You may initiate the external appeal process by filing a completed External Appeal application with the New York State Department of Insurance. You or your designee may file an external appeal application; but if it's filed by your designee, you must consent to it in writing. The Department of Insurance may request from you written confirmation of the appointment of a designee. In addition, your attending physician has the right to pursue an external appeal of a retrospective adverse claim determination. To do so, the attending physician must complete an External Appeal application for health care providers. You must sign an acknowledgment of the request and a consent to release of any medical records.

Under New York State law, the completed request for appeal must be filed within 45 days of either: the date upon which you receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

## **Covered Services and Exclusions**

In general, this plan does not cover experimental or investigational treatments. However, this plan shall cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

### **APPEALS OF ADMISSIONS FOR OR PROVISIONS OR CONTINUATION OF ACCESS TO END OF LIFE CARE FOR PERSONS DIAGNOSED WITH ADVANCED CANCER**

The following applies if a person: (i) has been diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than 60 days to live, as certified by the person's participating provider); and (ii) the participating provider, in consultation with the medical director of a facility specializing in the treatment of terminally ill patients and licensed pursuant to article 28 of the public health law, has determined that the person's care would be appropriately provided by such facility.

In the event **Aetna** disagrees with the admission of or provision or continuation of care of the person by the facility, **Aetna** must initiate an expedited external appeal as described above. However, until a decision is rendered, such admission for, provision of or continuation of the care by the facility will not be denied, and **Aetna** will continue to provide such coverage. The decision of the external appeals agent will be binding on all parties.

### ***Exhaustion of Process***

You must exhaust 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.

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You do not have to exhaust the Appeals Procedure in order to:  
Contact the New York State Department of Insurance to request an investigation of a  
complaint or appeal; or

File a complaint or external appeal with the New York State Department of Insurance.

Aetna will keep records of your complaint for 7 years.



**Ronald A. Williams**  
**Chairman, Chief Executive Officer, and President**

Rider: 1037  
NY SB 3986  
Issue Date: July 10, 2009