Aetna Life and Casualty (Bermuda) Limited

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

Policyholder	Aetna International World Traveler
Group Policy No.	GP-299440
Rider	Bermuda Complaint and Appeals Health Rider
Issue Date	April 16, 2013
Effective Date	April 1, 2013

The Effective Date of the Group Policy is August 1, 2004.

The Revised Effective Date of the Group Policy is April 1, 2013.

Your Plan Effective Date is the date your Member Employer joins the Plan. See your Member Employer for details.

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 or supply or benefit.

Such Adverse Benefit Determination may be based on, among other things:

- The covered person's 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 the life of the covered person;
- jeopardize the ability of the covered person to regain maximum function;
- cause the covered person 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 – Group Health Coverage
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 the covered person 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. The covered person 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 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.

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 the covered person to file an appeal.

Complaints
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
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 with respect to Group Health claims following the receipt of notice of an Adverse Benefit Determination to request your level one Appeal. Your appeal may be submitted by calling our Member Services Department using the telephone number displayed on your member ID Card or in writing to the Appeals Resolution Team address shown below:

Appeals Resolution Team
P.O. Box 14463
Lexington, KY 40512

Your appeals request should include:

- Your name;
- Your employer's name;
- Member ID (or U.S. Social Security Number)
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information (comments, documents, records) you would like to have considered.

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 – 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.

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 60 calendar days of receipt of the request for an Appeal, unless otherwise required by U.S. state law or non-U.S. legislation, if you are residing outside of the United States.

Level Two Appeal (Applies Only to Group Health Claims)
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 a level two Appeal.

Post-Service Claims
Aetna shall issue a decision within 60 calendar days of receipt of the request for a level two Appeal, unless otherwise required by U.S. state law or non-U.S. legislation, if you are residing outside of the United States. If you do not agree with such determination, you have the right to file a second request for review.

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 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.

Exhaustion of Process
You must exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- contact your U.S. state's Department of Insurance to request an investigation of a complaint or **Appeal**; or
- file a complaint or **Appeal** with 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, acting on behalf of Aetna Life & Casualty (Bermuda) Ltd.; or any matter within the scope of the Appeals Procedure.

President

Aetna Life and Casualty (Bermuda) Ltd.