Aetna Life Insurance Company

Hartford, Connecticut 06156

Amendment

Policyholder: AMERISAFE, INC.

Group Policy No.: GP- 881667

This Certificate Rider describes a change in your Certificate which applies to all employees who reside in Massachusetts and who are covered under a group policy issued by Aetna Life Insurance Company that provides Medical or Medical/Dental coverage.

The purpose of this Certificate Rider is to add the following provisions to your Certificate if they are not already included or to replace a corresponding provision which is included but which provides a lesser benefit or coverage.

Keep this Certificate Rider with your Certificate at all times.

This Certificate Rider is effective on the later of the date you become covered under the group policy and September 23, 2005.

If you are covered under an Aetna Medical, or Aetna Medical/Dental plan, your Certificate has been amended to include the following Appeals Procedure section:

Appeals Procedure

Definitions

Adverse Benefit Determination: A determination, based upon a review of information provided by Aetna or its designated utilization review organization, to deny, reduce, modify, or termination an admission, continued inpatient stay, or the availability of any other health care services for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

The written notice of an Adverse Benefit Determination shall include a substantive clinical justification that is consistent with generally accepted principal of professional medical practice and shall, at a minimum, also provide the following important information that will assist you in making an Appeal of the Adverse Determination, if you wish to do so:

- identify the specific information upon which the adverse determination was based;

- discuss the presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- specify any alternative treatment options covered by Aetna, if any;
- reference and include applicable clinical practice guidelines and review criteria; and
- a clear, concise and complete description of Aetna's formal internal Appeal process and the procedures for obtaining external review, including the procedure to request an expedited external review.

Appeal: An oral or written request to Aetna to reconsider a Complaint or an Adverse Benefit Determination.

Complaint: Any oral or written inquiry that has not been explained or resolved to the claimant's satisfaction within there (3) business days of the Inquiry or any matter concerning an Adverse Determination.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce, modify or terminate a previously approved course of treatment.

Inquiry: any communication that has not been subject to an Adverse Determination and that request redress or an action, omission or policy of Aetna.

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. Aetna shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within 2 (two) working days of obtaining all necessary information. Necessary information shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve an admission, procedure or service, Aetna shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the claimant and the provider within two (2) working days thereafter. In the case of an Adverse Determination for an utilization review decision, Aetna will notify the provider within 24 hours and then send written or electronic

confirmation of the telephone notification to the claimant and the provider within one (1) working day thereafter.

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-Utilization Review

Aetna will make notification of a claim determination as soon as possible but not later than within 24 hours of obtaining all necessary information after the pre-service claim is made. Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. Necessary information shall include the results of any face-to-face clinical evaluations or second opinions that may be required. The claimant may contact Member Services at the toll-free telephone number on your ID card to determine the status or outcome of utilization review decisions.

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 claimant will have 45 calendar days, from the date of the notice, to provide Aetna with the required information. Within 45 days from receipt of notice of a claim, if payment is not made, Aetna shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim, within the terms of the policy. If Aetna fails to provide this information, Aetna shall pay, in addition to any benefits, interest on such benefits, which shall accrue beginning 45 days after Aetna's receipt of notice of claim at the rate of 1½% per month, not to exceed 18% per year.

Concurrent Care Claim Extension-Utilization Review

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 and within one (1) working day of obtaining all necessary information with respect to all other care, following a request for a Concurrent Care Claim Extension.

With respect to all other care, following a request for a Concurrent Care Claim Extension:

in the case of a determination to approve a Concurrent Care Claim Extension, Aetna shall notify the **physician** rendering the service by telephone within one (1) working day and shall provide written or electronic confirmation to the claimant and the **physician** within one (1) working day thereafter. The written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved and the date of admission or initiation of services.

in the case of an Adverse Determination for a utilization review decision, Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. In the case of inpatient care, the claimant will be notified in writing of the Adverse Determination prior to discharge. The service shall be continued without liability to the claimant until notified of the determination.

The claimant may contact Member Services at the toll-free telephone number to determine the status or outcome of utilization review decisions.

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. In the case of an Adverse Determination for a utilization review decision, Aetna will notify the **physician** within 24 hours and then send written or electronic confirmation of the telephone notification to the claimant and the **physician** within one (1) working day thereafter. The service shall be continued without the liability until the claimant has been notified of the determination.

Utilization Review Reconsideration Process

Aetna shall give a **physician** an opportunity to seek reconsideration of a utilization review Adverse Determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) working day of the receipt of the request and shall be conducted between the **physician** rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one (1) working day. If the reconsideration process does not reverse the utilization review Adverse Determination, the claimant or the **physician**, on behalf of the claimant, may pursue the Appeal process. The reconsideration process shall not be a prerequisite to the Appeal process or an expedited Appeal.

Inquiries

The Inquiry process is a process prior to the Appeal process during which Aetna may attempt to answer questions and/or resolve concerns communicated on behalf of the claimant to their satisfaction within three (3) business days. This process shall not be used for review of an Adverse Determination, which must be reviewed through the Appeal process.

Aetna will address any Inquiries as expeditiously as possible, and provide a call back within 24 hours. A claimant whose Inquiry has not been explained or resolved to their satisfaction within three (3) business days of the Inquiry, has the right to have the Inquiry processed as a Complaint at their option, including reduction of an oral Inquiry to writing by Aetna, written acknowledgement and written resolution of the Complaint.

Aetna maintains records of each Inquiry communicated by a claimant or on their behalf and each response thereto, for a minimum period of two (2) years. These records are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

Complaints

If an Inquiry is not resolved in three (3) business days or 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 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

Please refer to the Expedited Appeal Process section for information regarding certain types of claims that may be eligible for an expedited Appeal process.

You may submit an Appeal if Aetna gives notice about a Complaint or 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 and Group Disability claims and 60 calendar days with respect to all Other Group claims following the receipt of notice about a Complaint or an Adverse Benefit Determination to request your level one Appeal. Your appeal must be made by telephone, in person, by mail, or by electronic means 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.

Oral Appeals made by a claimant, or the authorized representative, shall be reduced to writing by Aetna and a copy thereof forwarded to the claimant, or authorized representative, by Aetna within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement of the claimant or the claimant's authorized representative and Aetna.

A written acknowledgement of the receipt of an Appeal shall be sent to the claimant or the claimant's authorized representative, if any, within 15 business days of said receipt, except where an oral Appeal has been reduced to writing by Aetna or this time period is waived or extended by mutual written agreement of the claimant or the claimant's authorized representative and Aetna.

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.

A claimant may contact Member Services at the toll-free telephone number on their ID card for assistance in resolving Appeals. A claimant may also contact the Office of Patient Protection at their toll-free number (1-800-436-7757), facsimile (617-624-5046) or via the internet site (www.state.ma.us/dph/opp) regarding an external appeal.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. All rights of the claimant also extend to the claimant**'s** authorized representative, which includes a claimant's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to the law, family member, or another person authorized by the claimant in writing or by law with respect to a specific Appeal or external review, provided that if the claimant is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order or priority may be the claimant's representative or appoint another responsible party to serve as the claimant's authorized representative. If the authorized representative is a health care provider, the claimant must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

The described two-level Appeal process will be completed within 30 business days, regardless of the number of levels in the process. When an Appeal requires the review of medical records, the 30 business day period will not begin to run until the claimant, or the claimant's authorized representative, submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the claimant, or the claimant's authorized representative, if any, within 30 business days of the receipt of the Appeal, Aetna may, in its discretion, issue a resolution of the Appeal without review of some or all of the medical records.

Appeals shall be reviewed by an individual or individuals who are knowledgeable about the matters at issue with the Appeal.

Appeals shall be reviewed with the participation of an individual or individuals who did not participate in any of Aetna's prior decisions of the Appeal. In at least one level of review of an Appeal, the Appeal shall be reviewed with the participation of an individual who is an actively practicing health care professional in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment that is the subject of the Appeal.

Any second level of Appeal is strictly voluntary and not a prerequisite to filing an external appeal to the Office of Patient Protection.

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 Complaint or 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.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an Adverse Determination to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an Adverse Determination for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claim has been notified of the decision.

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.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an Adverse Determination to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an Adverse Determination for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claim has been notified of the decision.

Post-Service Claims

Aetna shall issue a both a level one and a level two decision within 30 business days of receipt of the request for an Appeal.

The time limits stated above may be waived or extended by mutual written agreement of the claimant or the claimant's authorized representative, and Aetna. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the claimant does not agree to an extension, Aetna shall make a decision based on the information available.

If Aetna fails to reduce an oral Appeal to writing and forward a copy to the claimant within 48 hours, fails to provide written acknowledgement of the receipt of an Appeal to the claimant within 15 business days or fails to complete the two-level Appeal process within 30 business days, an Appeal shall be deemed resolved in favor of the claimant. Time limits include any extensions made by mutual written agreement of the claimant, or the claimant's authorized representative, if any, and Aetna.

A written notice stating the results of the Appeal of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

- identify the specific information upon which the Complaint or Adverse Determination was based;
- discuss the claimant's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- specify alternative treatment options covered by Aetna, if any;
- reference and include applicable clinical practice guidelines and review criteria; and
- notify the claimant or the claimant's authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

Aetna will furnish the claimant with a copy of the form prescribed by the Department for filing the request for an external review (see External Review).

If an Appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Aetna's expense through completion of the internal Appeal process, regardless of the original internal Appeal decision, provided the Appeal is filed on a timely basis, based on the course of treatment. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by Aetna and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the claimant's contract for benefits.

Level Two Appeal --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 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.

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.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an Adverse Determination to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an Adverse Determination for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claim has been notified of the decision.

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.

Aetna shall issue a concurrent review decision within one working day of obtaining all necessary information.

In the case of a decision to reverse an Adverse Determination to approve an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the claimant and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, and the new total number of days or services approved, and the date of admission or initiation of services.

In the case of a decision to uphold an Adverse Determination for an extended stay or additional services, Aetna shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the claimant and the provider within one working day thereafter. The service shall be continued without liability to the claimant until the claim has been notified of the decision.

Post-Service Claims

Aetna shall issue both a level one and a level two decision within 30 business days of receipt of the request for an Appeal.

The time limits stated above may be waived or extended by mutual written agreement of the claimant or the claimant's authorized representative, and Aetna. Any such agreement shall state the additional time limits, which shall not exceed 30 business days from the date of the agreement. If additional information is required and the claimant does not agree to an extension, Aetna shall make a decision based on the information available.

If Aetna fails to reduce an oral Appeal to writing and forward a copy to the claimant within 48 hours, fails to provide written acknowledgement of the receipt of an Appeal to the claimant within 15 business days or fails to complete the two-level Appeal process within 30 business days, an Appeal shall be deemed resolved in favor of the claimant. Time limits include any extensions made by mutual written agreement of the claimant, or the claimant's authorized representative, if any, and Aetna.

A written notice stating the results of the Appeal of the Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principals of professional medical practice that shall at a minimum:

- identify the specific information upon which the Complaint or Adverse Determination was based;
- discuss the claimant**'**s presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
- specify alternative treatment options covered by Aetna, if any;
- reference and include applicable clinical practice guidelines and review criteria; and
- notify the claimant or the claimant's authorized representative of the procedures for requesting external review, including the procedure to request an expedited external review.

Aetna will furnish the claimant with a copy of the form prescribed by the Department for filing the request for an external review (see External Review).

If an Appeal is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at Aetna's expense through completion of the internal Appeal process, regardless of the original internal Appeal decision, provided the Appeal is filed on a timely basis, based on the course of treatment. Ongoing coverage or treatment include only that medical care that, at the time it was initiated, was authorized by Aetna and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the claimant's contract for benefits.

Expedited Appeals Review Process

1. In the event the claimant is a hospital inpatient, the claimant shall receive a written resolution of an expedited review of the Appeal prior to hospital discharge and the opportunity to request continuation of services. If the expedited review results in an Adverse Determination regarding the continuation of inpatient care, the written resolution must inform the claimant or the claimant's authorized representative of the opportunity to request an expedited external review if the treating **physician** certifies in writing, that delay in the continuation of inpatient services would pose a serious and immediate threat to the health of the claimant. While the claimant is a hospital inpatient, a health care provider or a representative of the hospital may act as the claimant's representative without the need for a written authorization from the claimant.

2. In the event the Appeal is of an emergent or urgent nature where the **physician** believe that denial of coverage for medically necessary service would cause serious harm to the claimant, an Aetna Medical Director shall review the matter as soon as possible or within 48 hours and communicate a decision to the claimant by telephone. In addition, Aetna will provide the claimant with a written resolution which shall include identification of the specific information considered and an explanation of the basis for he decision. The written resolution shall include a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice.

3. Within 48 hours of receipt of certification by the **physician** responsible for treatment or proposed treatment that is the subject of the appeal that, in the **physicia**n's opinion:

   - the service is medically necessary;
   - a denial of coverage for such services would create a substantial risk of serious harm to the claimant; and
   - such risk of serious harm is so immediate that the provision of such services should not wait the outcome of the normal Appeal process.

4. Within less than 48 hours of receipt of certification by the physician who ordered any durable medical equipment that is subject to appeal, Aetna will provide the claimant with a written resolution when such physician:

   - certifies that the use of the durable medical equipment is medically necessary;
   - certifies that a denial of coverage for such durable medical equipment would create substantial risk of serious harm to the patient;
   - certifies that such risk of such serious harm is so immediate that the provision of such durable medical equipment should not await the outcome of the normal appeals process;
   - describes the specific, immediate and severe harm that will result to the patient absent action within the 48 hours; and
   - specifies a reasonable time period in which Aetna must provide a response.

5. If the expedited review process set forth in 3 or 4 above results in an adverse determination, the written resolution will inform the claimant, or the claimant's representative, of the opportunity to request an expedited external review, and if the review involves the termination of ongoing services, the opportunity to request continuation of services during the period the review is pending. Any such continuation shall be at Aetna's expense, regardless of the final external review determination.

6. In the event the claimant has a terminal illness, a resolution shall be provided to the claimant or authorized representative within five (5) days from the receipt of the Appeal.

   If the expedited review process affirms the denial of coverage to a claimant with a terminal illness, Aetna shall provide the claimant, within five (5) business days of the decision:

   - a statement setting forth the specific medical and scientific reasons for denying coverage;
   - a description of alternative treatment, services or supplies covered by Aetna, if any; and
   - the procedure the claimant to request a conference.

   Aetna shall schedule such conferences within ten (10) days of receiving the request for a conference from the claimant. At the conference the information provided to the claimant pursuant to provisions (1) and (2) above shall be reviewed by the claimant and a representative of Aetna who has authority to determine the disposition of the Appeal. Aetna shall permit attendance at the conference of the claimant, a designee of the claimant or both, or, if the claimant is a minor or incompetent, the parent guardian or conservator of the claimant as appropriate. The conference shall be held within five (5) business days if the treating **physician** determines, after consultation with Aetna's Medical Director or designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by Aetna, would be materially reduced if not provided at the earliest possible date.

External Review

A claimant**,** who remains aggrieved by an Adverse Determination and has exhausted at least one level of Appeal, may seek further review of the Appeal by filing a request in writing with the Office of Patient Protection. The request for an external review must be made within 45 days of receipt of the Aetna determination. For the purposes of this provision, an Adverse Determination is based upon a review of information provided by Aetna to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care or effectiveness.

A claimant or the claimant's authorized representative, if any, may request to have their request for review processed as an expedited external review.

Any request for an expedited external review shall contain a certification, in writing, from a **physician**, that delay in the providing or continuation of health care services that are the subject of a final Adverse Determination, would pose a serious and immediate threat to the health of the claimant.

Upon finding that a serious and immediate threat to the claimant exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

A claimant seeking a review shall pay a fee of $ 25.00, to the Office of Patient Protection, which shall accompany the request for a review. The fee may be waived by said office if it determines that the payment of the fee would result in an extreme hardship to the claimant.

The remainder of the cost for an external review shall be borne by Aetna. Upon completion of the external review, the Office of Patient Protection shall bill Aetna the amount established pursuant to a contract between the Department and the assigned external review agency minus the $ 25.00 fee, which is the claimant's responsibility.

In connection with any request for an external review, Aetna shall assure that the claimant, and where applicable the claimant's authorized representative, have access to any medical information and records relating to the claimant in possession of Aetna or under Aetna's control.

Request for a review submitted by the claimant or the claimant's authorized representative shall:

- Be on a form prescribed by the Department;
- Include the signature of the claimant or the claimant's authorized representative consenting to the release of medical information;
- Include a copy of the written final Adverse Determination issued by Aetna; and
- Include the required $ 25.00 fee.

If the subject matter of the external review involves the termination of ongoing services, the claimant may Appeal to the external review agency to seek the continuation of coverage for the terminated service during the period the review is pending. Any such request must be made before the end of the second business day following receipt of the final Adverse Determination. The external review agency may order the continuation of coverage or treatment where it determines that substantial harm to the claimant's health may result absent such continuation or for such other good cause as the external review agency shall determine. Any such continuation of coverage shall be at Aetna's expenses regardless of the final external review determination.

The decision of the review panel shall be binding.

If the external review agency overturns Aetna's decision in whole or in part, Aetna shall issue a written notice to the claimant within five (5) business days of receipt of the written decision from the external review agency. Such notice shall:

- acknowledge the decision of the review agency;
- advise the claimant of any additional procedures for obtaining the requested coverage of services;
- advise the claimant of the date by which the payment will be made or the authorization for services will be issued by Aetna; and
- advise the claimant of the name and phone number of the person within Aetna who will assist the claimant with final resolution of the appeal.

The Office of Patient Protection, established by the Department of Public Health, is responsible for the administration and enforcement of certain Massachusetts Managed Care requirements. A claimant may contact the Office of Patient Protection to obtain a report detailing, for the previous calendar year, the total number:

- a list of sources of independently published information assessing insureds' satisfaction and evaluating the quality of health care services offered by Aetna.
- the percentage of **physicians** who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary **physician** disenrollment.

- the percentage of premium revenue expended by the carrier for health care services provided to insureds' for the most recent year for which information is available; and
- a report detailing, for the previous calendar year, the total number of:

  filed Appeals, Appeals that were approved internally, Appeals that were denied internally and Appeals that were withdrawn before resolution; and

  External Appeals pursued after exhausting the internal Appeals process and the resolution of all such Appeals.

Ronald A. Williams
President

Project Rider – MA Reg. 105 CMR 128
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