

SERFF Tracking Number: IADC-126565453 State: Arkansas
Filing Company: Independence American Insurance Company State Tracking Number: 45307
Company Tracking Number: IAIC HEARING AID RIDER
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Act 1179 Compliance - Hearing Aids
Project Name/Number: /

Filing at a Glance

Company: Independence American Insurance Company

Product Name: Act 1179 Compliance - Hearing Aids SERFF Tr Num: IADC-126565453 State: Arkansas

Aids

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 45307

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: IAIC HEARING AID RIDER State Status: Approved-Closed

Filing Type: Form

Author: Shellie Howard

Date Submitted: 03/30/2010

Reviewer(s): Rosalind Minor

Disposition Date: 05/19/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/19/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/19/2010

Created By: Shellie Howard

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Shellie Howard

Filing Description:

Hearing aid benefit rider to comply with Act 1179 and bulletin 7A-2009. Please see cover letter for additional details

Company and Contact

Filing Contact Information

Shellie Howard, Forms Development &
Compliance Specialist

howards@iacusa.com

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2101 W. Peoria Ave 602-861-6070 [Phone]
 Suite 100
 Phoenix, AZ 85029-4925

Filing Company Information

Independence American Insurance Company	CoCode: 26581	State of Domicile: Delaware
485 Madison Avenue	Group Code: 450	Company Type: Life and Health
New York , NY 10022	Group Name:	State ID Number:
(212) 355-4141 ext. [Phone]	FEIN Number: 74-1746542	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$40.00
Retaliatory?	No
Fee Explanation:	\$20 PER FORM
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Independence American Insurance Company	\$40.00	03/30/2010	35268811
Independence American Insurance Company	\$60.00	05/17/2010	36597332

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/19/2010	05/19/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/12/2010	05/12/2010	Shellie Howard	05/17/2010	05/17/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Filing Fee	Note To Filer	Rosalind Minor	04/02/2010	04/02/2010

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Disposition

Disposition Date: 05/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

As requested, Form IAIC MED BSF AR 0310 is being withdrawn effective on this date.

The remaining forms are approved effective on this date.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd Party Authorization	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	[Optional] Hearing Aid Benefit Rider	Approved-Closed	Yes
Form (revised)	Benefit Selection Form	Withdrawn	Yes
Form	Benefit Selection Form	Withdrawn	Yes
Form	Policyholder election form	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/12/2010
Submitted Date 05/12/2010
Respond By Date 05/19/2010

Dear Shellie Howard,

This will acknowledge receipt of the captioned filing.

Objection 1

- [Optional] Hearing Aid Benefit Rider, IAIC HEARDAIDAE AR 0310 (Form)

Comment:

On 4/2/10, I sent a Note to Filer requesting an additional filing fee in the amount of \$60.00.

If the filing fee is not received by 5/19/10, the filing will be disapproved.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/17/2010
Submitted Date 05/17/2010

Dear Rosalind Minor,

Comments:

Please find response below:

Response 1

Comments: Please withdraw our request for approval for form IAIC MED BSF AR 0310. I am adding a policyholder election form IAIC AEAR OPT ELC AR 0510, and submitting an additional \$60 to satisfy the difference in fee schedule.

Related Objection 1

Applies To:

- [Optional] Hearing Aid Benefit Rider, IAIC HEARDAIDAE AR 0310 (Form)

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Comment:

On 4/2/10, I sent a Note to Filer requesting an additional filing fee in the amount of \$60.00.

If the filing fee is not received by 5/19/10, the filing will be disapproved.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Benefit Selection Form	IAIC MED BSF AR 0310		Other	Revised	ICCI- 12526663 1/St #39791		
Previous Version							
Benefit Selection Form	IAIC MED BSF AR 0310		Other	Revised	ICCI- 12526663 1/St #39791		IAIC MED BSF AR 0310 (Plan Selection) For Filing 033010.pdf
Policyholder election form	IAIC AEAR OPT ELC AR 0510		Other	Initial			IAIC AEAR OPT ELC AR 0510 for filing 051710.pdf

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No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Sincerely,
Shellie Howard

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Note To Filer

Created By:

Rosalind Minor on 04/02/2010 03:20 PM

Last Edited By:

Rosalind Minor

Submitted On:

05/19/2010 12:53 PM

Subject:

Additional Filing Fee

Comments:

Our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The fee for this submission should be \$50.00 per form for a total of \$100.00. Please submit an additional \$60.00 for this submission.

We will begin our review of this submission upon receipt of the additional fee.

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/19/2010	IAIC HEARAIDA E AR 0310	Certificate	[Optional] Hearing Aid Benefit Rider	Initial			IAIC HEARAIDAE AR 0310 (Optional Hearing Aid Rider)033010. pdf
Withdrawn 05/19/2010	IAIC MED BSF AR 0310	Other	Benefit Selection Form	Revised	Replaced Form #: IAIC MED BSF 107 Previous Filing #: ICCI-125266631/St #39791		
Approved-Closed 05/19/2010	IAIC AEAR OPT ELC AR 0510	Other	Policyholder election form	Initial			IAIC AEAR OPT ELC AR 0510 for filing 051710.pdf

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

**[OPTIONAL] HEARING AID BENEFIT RIDER
FOR ARKANSAS RESIDENTS ONLY**

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

If You are covered under the [optional] Hearing Aid Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended as follows:

A. SECTION 4 – BENEFITS the following benefit is added:

[21.] Hearing Aids, not subject to Calendar Year Deductible [or Daily Deductible] or Copay, up to \$[1,400] per ear for each [three-year] period. The Hearing Aids must be dispensed by an individual properly licensed by the State of Arkansas.

B. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE the following change is hereby made:

Item [#24] pertaining to routine hearing exams is amended by deleting the reference to “the purchase of hearing aids.”

C. SECTION 11 – DEFINITIONS the following definition is added:

Hearing Aid means an instrument or device, including repair and replacement parts, that:

- a) Is designed and offered for the purpose of aiding Covered Persons with or compensating for impaired hearing;
- b) Is worn in or on the body; and
- c) Is generally not useful to a person in the absence of a hearing impairment.

TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2009] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
[A Delaware Company]

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.] Accept _____ Reject _____ Hearing Aids (Act 1179 of 2009/Bulletin 7A-2009)

As the Policyholder, we request that you indicate above whether you accept or reject this optional benefit:

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/19/2010
Comments:		
Attachment: ARCertificate of ComplianceIAIC033010.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	05/19/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: 3rd Party Authorization	Approved-Closed	05/19/2010
Comments:		
Attachment: IAIC Authorization Letter 2010.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	05/19/2010
Comments:		
Attachment: IAIC(AR)filing letter 033010.pdf		

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Independence American Insurance Company

Form Number(s):

IAIC HEARDAE AR 0310

IAIC MED BSF AR 0310

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer:



Adam Vandervoort
Name

Secretary
Title

03/30/10
Date



www.independenceamerican.com

January 6, 2010

RE: Independence American Insurance Company

NAIC Company Number: 26581
NAIC Group Number: 0450
FEIN Number: 74-1746542

AUTHORIZATION STATEMENT

Independence American Insurance Company ("IAIC") hereby authorizes IHC Health Solutions (Member of the IHC Group) to represent us in the submission of accident and health insurance forms and rates and to negotiate with the Department for their approval.

Sincerely,

A handwritten signature in black ink, appearing to read "Adam Vandervoort".

Adam C. Vandervoort
Secretary



2101 W Peoria Avenue #100
Phoenix, AZ 85029

March 30, 2010

Honorable Jay Bradford
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Independence American Insurance Company
NAIC Company Number: 26581
NAIC Group Number: 0450
FEIN Number: 74-1746542
Master Group Major Medical Insurance Policy – IAIC GP 107 and Related Forms

New Form:
IAIC HEARDAE AR 0310 [Optional] Hearing Aid Benefit Rider

Revised Form:
IAIC MED BSF AR 0310 Benefit Selection Form

Dear Commissioner Bradford:

We are submitting for your review and approval, the above referenced out-of-state Group Policy forms on behalf of Independence American Insurance Company{IAIC}. This filing is being made in order to comply with Bulletin 7A-2009 & Act 1179 of 2009 regarding the mandatory offering of hearing aids. The Hearing Aid Benefit Rider is a new form and will not replace any approved forms currently on file with the Department. The Benefit Selection Form was revised to reflect the new hearing aid option. This form will replace IAIC MED BSF 107 approved 08/26/2008 under State Tracking #39791, SERFF #ICCI-125266631. We will list this rider on the Schedule of Benefits as applicable or not applicable, depending on the applicant's selection.

IHC has received authorization to file life, accident, and health forms on IAIC's behalf. For your reference, we have enclosed the filing letter of authorization from IAIC. Additionally, we have also included a Certification signed by an officer of IAIC, in accordance with Rule and Regulation 19.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. We confirm that the forms meet the minimum required readability standards.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: howards@iacusa.com. Thank you for your prompt consideration of this filing.

Sincerely,

Shellie Howard

Shellie Howard
Form Development & Compliance Specialist
PH: 602-861-6070

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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/30/2010	Form	Benefit Selection Form	05/17/2010	IAIC MED BSF AR 0310 (Plan Selection)For Filing 033010.pdf (Superseded)

[PLAN NAME] BENEFIT SELECTION FORM

Underwritten by Independence American Insurance Company

CASE NUMBER _____

APPLICANT'S NAME _____ (LAST) (FIRST) (INITIAL)	SOCIAL SECURITY NUMBER _____
--	-------------------------------------

PLAN SELECTION: Design your plan by selecting your In-Network plan options. Out-of-Network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

[Plan 1	[Plan 2	[Plan 3	[Plan 4	[Plan 5	[Plan 6
<u>Copay</u> <input type="checkbox"/> \$0-\$100					
<u>Deductible</u> <input type="checkbox"/> \$0-\$20,000					
<u>Coinsurance</u> <input type="checkbox"/> 50%-100%					
<u>Maximum out-of-pocket options:</u> <input type="checkbox"/> \$0 - \$50,000					

Preferred Provider Organization (PPO) Network Selected:

Optional Benefits

[Outpatient Prescription Drug Coverage]	<input type="checkbox"/> Deductible & Coinsurance <input type="checkbox"/> Drug Card Outpatient Rx covered the same as any other illness.
[18-Month Rate Guarantee]	<input type="checkbox"/> Yes <input type="checkbox"/> No (12-Month Rate Guarantee will apply if not elected)
[Preventive Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Supplemental Accident]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Maternity Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Dental Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Vision Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Hearing Aid Coverage]	<input type="checkbox"/> Yes <input type="checkbox"/> No [Not available on HSA-qualified High Deductible Health Plans]
[24-hour Occupational Coverage]	[Sole proprietors, partners (ownership over 10%), or business owners not covered by Workers' Compensation are eligible. Do you or your spouse qualify for this benefit? (Verification may be necessary.) Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

Attach this form to your *Application for Insurance*

For Administrative Use Only

Case Number	Enter	Date	Approved By	Date	Eff Date	PCEFD