

SERFF Tracking Number: UCIN-126743116 State: Arkansas  
 Filing Company: United Concordia Insurance Company State Tracking Number: 46392  
 Company Tracking Number: AR/UCIC/002-10  
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental  
 Product Name: Employer Paid  
 Project Name/Number: State Law Provisions Addendum/AR/UCIC/002-10

## Filing at a Glance

Company: United Concordia Insurance Company

Product Name: Employer Paid

SERFF Tr Num: UCIN-126743116 State: Arkansas

TOI: H10G Group Health - Dental

SERFF Status: Closed-Approved-Closed  
 State Tr Num: 46392

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: AR/UCIC/002-10

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Michelle Shutt, Benjamin Schaefer, Krista Maddigan

Disposition Date: 08/09/2010

Date Submitted: 08/04/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: State Law Provisions Addendum

Status of Filing in Domicile: Not Filed

Project Number: AR/UCIC/002-10

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This filing is specific to Arkansas.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 08/09/2010

Explanation for Other Group Market Type:

State Status Changed: 08/09/2010

Deemer Date:

Created By: Michelle Shutt

Submitted By: Michelle Shutt

Corresponding Filing Tracking Number:

Filing Description:

United Concordia Insurance Company (UCIC), a Life, Accident and Health Insurer, is submitting this filing for approval. The filing contains the State Law Provisions Addendum to the Certificate of Insurance. The Addendum was revised in pursuant to AR Rule 21 to conform to the most recent NAIC COB Model Regulation. A marked up copy showing the changes from the previously approved form is included for your reference. UCIC markets dental insurance only.

## Company and Contact

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**Filing Contact Information**

Michelle Shutt, Regulatory Compliance Analyst ucdoicorro@ucci.com  
 4401 Deer Path Road 800-929-0538 [Phone] 57278 [Ext]  
 Harrisburg, PA 17110 717-260-6888 [FAX]

**Filing Company Information**

United Concordia Insurance Company	CoCode: 85766	State of Domicile: Arizona
4401 Deer Path Road	Group Code: 812	Company Type: LAH
Harrisburg, PA 17110	Group Name: Highmark	State ID Number:
(800) 929-0538 ext. 57225[Phone]	FEIN Number: 86-0307623	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Concordia Insurance Company	\$50.00	08/04/2010	38508261

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/09/2010	08/09/2010

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## Disposition

Disposition Date: 08/09/2010

Implementation Date:

Status: Approved-Closed

Comment:

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	Markup of the State Law Provisions Addendum	Approved-Closed	Yes
Form	State Law Provisions Addendum to the Certificate of Insurance	Approved-Closed	Yes

SERFF Tracking Number: UCIN-126743116 State: Arkansas  
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## Form Schedule

### Lead Form Number: AR9804A (07/10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/09/2010	AR9804A (07/10)	Certificate	State Law Provisions Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.000	AR State Law Provisions 0710.pdf

**STATE LAW PROVISIONS ADDENDUM**  
**TO**  
**CERTIFICATE OF INSURANCE**

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following provision is added to "Dependents" in the "Definitions" section of the Certificate:

**DEFINITIONS**

**Dependents**

And, any unmarried child of the Certificate Holder who is the subject of a case being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law,

The following subsection " Enrollment Changes" is removed from the "Eligibility and Enrollment – When Coverage Begins" section of the Certificate and the following substituted:

**ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS**

**Enrollment Changes**

{After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth
- adoption
- court order of placement or custody
- cases being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law
- change in student status for a child
- marriage.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the {first day of the month following the} date specified in the enrollment information provided to Us as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. In order for coverage of newly born to continue beyond the first 90 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 90 day period.

In order for coverage of adoptive children to continue beyond the first 60 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 60 day

period. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within 60 days of birth who will be considered enrolled Dependents from the moment of birth. Coverage for adoptive children shall be effective on the date of the filing of a petition for adoption. In order for coverage of petitioned adoptive children to continue beyond the 60 day period, notification of petition and payment of the required Premium shall be furnished to Us by You within the 60 day period. Coverage for petitioned adoptive children shall terminate upon dismissal or denial of the petition for adoption.

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, We request that notice of his/her reliance on You for maintenance and support due to his/her condition be supplied to Us after said Dependent attains the limiting age shown in the definition of Dependent.

If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

{Dependent coverage may only be terminated when certain life change events occur including death, divorce or reaching the limiting age {or during open enrollment periods.} {unless otherwise specified in any applicable Late Entrant Rider to the Certificate of Insurance.}}

The following provision is added to the "Late Enrollment" subsection(s) of the Certificate:

### **Late Enrollment**

In the instance where a Certificate Holder is required by a court or administrative order, or in cases being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law, to provide health coverage for an unmarried child, and the Certificate Holder fails to make application to obtain coverage for the child, We will enroll the child upon application of the child's other parent, or the state agency administering the federal child enforcement program. We will not disenroll or eliminate coverage of the child unless provided with written evidence that the court or administrative order is no longer in effect, or that the child is or will receive coverage through another plan with an effective date no later than the effective date of disenrollment.

The "Coordination of Benefits" subsection of the "BENEFITS" section of the Certificate is completely removed and replaced with the following:

### **Coordination of Benefits (COB)**

The Coordination of Benefits ("COB") provision applies when a Member has health care coverage under more than one Plan (defined below). The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed one-hundred percent (100%) of the total Allowable Expense (defined below).

1. The following words/phrases regarding Coordination of Benefits (“COB”) are defined as set forth below:
  - A. **Plan**, for the purpose of this COB section, is any of these which provides benefits or services for, medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts:
    - (1) **Plan** includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage, whether insured or uninsured. “Plan” also includes medical care components of long-term care contracts, such as skilled nursing care, medical benefits under group or individual automobile contracts and Medicare or any other federal governmental plan, as permitted by law.
    - (2) **Plan** does not include hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal government plans, unless permitted by law.
  - B. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans.
  - C. The **Order of Benefit Determination Rules** state whether this Plan is a Primary Plan or a Secondary Plan when the Member has health care coverage under more than one Plan.
    - (1) When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.
    - (2) When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits and may reduce the benefits it pays so that all Plan benefits do not exceed one-hundred percent (100%) of the total allowable expense.
  - D. **Allowable Expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by a Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Member is not an Allowable Expense.
    - (1) The following are examples of expenses that are not Allowable Expenses:
      - a. The difference between the cost of a resin-based composite filling and the cost of an amalgam filling is not an Allowable Expense unless one of the Plans provides coverage for resin-based composite fillings.
      - b. If a Member is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

- c. If a Member is covered by two (2) or more Plans that provide benefit payment on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  - d. If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
  - e. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E. **Closed Panel Plan** is a Plan that provides health care benefits to covered person's primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the Parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## 2. Order of Benefit Determination Rules

When a Member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- B. (1) Except as provided in Paragraph (2) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this rule is always primary unless the provisions of both plans state that the complying Plan is primary.
  - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculation payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
  - (1) Non-Dependent/Dependent. The Plan which covers the Member other than as dependent, for example as an employee, member, policyholder, subscriber or retiree is

the Primary Plan and the Plan that covers the Member as a dependent is the Secondary Plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a dependent; and primary to the Plan covering the Member as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in a calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that has covered the parent longest is the Primary Plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- (a) The Plan of the parent with custody of the child;
- (b) The Plan of the spouse of the parent with the custody of the child;
- (c) The Plan of the parent not having custody of the child; and
- (d) The Plan of the spouse of the parent not having the custody of the child;

(2) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the dependent child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;

(3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subpart 2.D.(2)a above shall determine the order of benefits.

(4) If the court decree states that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses of the dependent child, the provisions of subpart 2.D.(2)a above shall determine the order of benefits.

c. For a dependent child covered under more than one Plan of individuals who are not parents of the child, the provisions of subparts 2.D.(2)a or 2.D.(2)b above shall determine the order of benefits as if those individuals were the parents of the child.

E. Active Employees or Retired or Laid-Off Employees. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The Plan covering the same Member as a retired or laid-off employee is the Secondary Plan. The same would hold true if a Member is a dependent of an active employee and the same Member is a dependent of a retired or laid-off employee. If the other Plan does not have this

rule, and as a result, the Plans do not agree this rule is ignored. This rule does not apply if the rule labeled D(1) of this section can determine the order of benefits.

- F. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree or covering the Member as a dependent of an employee member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plans do not have this rule, and as a result, the Plans do not agree on the order of benefits this rule is ignored. This rule does not apply if the rule labeled D(1) of this section can determine the order of benefits.
  - G. Longer or Shorter Length of Coverage. The Plan that covered a Member as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan which covered that Member for the shorter period of time is the Secondary Plan.
  - H. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition this Plan will not pay more than it would have paid had it been the Primary Plan.
- 3. Effect on the Benefits of this Plan - When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of another health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
  - 4. Right to Receive and Release Needed Information - Certain facts about health care coverage are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules and to determine benefits payable under This Plan and other Plans covering the Member claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable.
  - 5. Facility of Payment - A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
  - 6. Right of Recovery - If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the Members it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered Member.
  - 7. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The following provision is added to the "Claims Submission" subsection of the "How the Dental Plan Works" section of the Certificate:

### **HOW THE DENTAL PLAN WORKS**

#### **Claims Submission**

For an unmarried child who has coverage through a noncustodial parent, We will provide information to the custodial parent necessary for the child to obtain benefits through that coverage.

The following provision is added to the "Payment of Benefits" subsection of the "Benefits" section of the Certificate:

### **BENEFITS**

#### **Payment of Benefits**

For an unmarried child who has coverage through a noncustodial parent who is the Certificate Holder, We will permit the custodial parent or provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent who is the Certificate Holder. We will make payments on claims submitted by the custodial parent or provider for covered services directly to the custodial parent, the provider or the required state agency.

The following provision and subsection are added to the "General Provisions" section(s) of the Certificate:

### **GENERAL PROVISIONS**

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Arkansas.

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 Project Name/Number: State Law Provisions Addendum/AR/UCIC/002-10

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	08/09/2010
<b>Comments:</b> Attached is the signed readability certification		
<b>Attachment:</b> AR Signed Readability Certification.pdf		

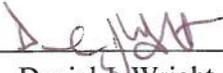
	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	08/09/2010
<b>Comments:</b> The State Law Provisions Addendum to the Certificate of Insurance will be used with one of the previously approved applications, Form Nos. 9801L (07/05), 9801-SM (07/05), and 9801BP (07/05). All applications were approved on 06/27/2005.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Markup of the State Law Provisions Addendum	Approved-Closed	08/09/2010
<b>Comments:</b> Attached is a markup of the State Law Provisions Addendum for your reference.		
<b>Attachment:</b> AR State Law Provisions 0710 Markup.pdf		

**READABILITY CERTIFICATION**

I, Daniel J. Wright, Vice President of Finance of United Concordia Insurance Company, do hereby certify and affirm that the attached State Law Provisions Addendum to the Certificate of Insurance, Form Number AR9804A (07/10) rates 40.0 on the Flesch Reading Ease Test Scale, meeting the minimum Flesch Score of 40 required by the state of Arkansas pursuant to, Ark. Code Ann.23§80-206(d) (1979).

Date: 7/28/2010

Signature:   
Daniel J. Wright  
Vice President, Finance

**STATE LAW PROVISIONS ADDENDUM**  
**TO**  
**CERTIFICATE OF INSURANCE**

This addendum is effective on the Effective Date as stated in the Certificate of Insurance “Certificate” and attached to and made part of the Certificate.

The following provision is added to “Dependents” in the “Definitions” section of the Certificate:

**DEFINITIONS**

**Dependents**

And, any unmarried child of the Certificate Holder who is the subject of a case being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law,

The following subsection “ Enrollment Changes” is removed from the “Eligibility and Enrollment – When Coverage Begins” section of the Certificate and the following substituted:

**ELIGIBILITY AND ENROLLMENT – WHEN COVERAGE BEGINS**

**Enrollment Changes**

{After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth
- adoption
- court order of placement or custody
- cases being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law
- change in student status for a child
- marriage.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the {first day of the month following the} date specified in the enrollment information provided to Us as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. In order for coverage of newly born to continue beyond the first 90 day period, the child’s enrollment information must be provided to Us and the required Premium must be paid within the 90 day period.

In order for coverage of adoptive children to continue beyond the first 60 day period, the child’s enrollment information must be provided to Us and the required Premium must be paid within the 60 day

period. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within 60 days of birth who will be considered enrolled Dependents from the moment of birth. Coverage for adoptive children shall be effective on the date of the filing of a petition for adoption. In order for coverage of petitioned adoptive children to continue beyond the 60 day period, notification of petition and payment of the required Premium shall be furnished to Us by You within the 60 day period. Coverage for petitioned adoptive children shall terminate upon dismissal or denial of the petition for adoption.

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, We request that notice of his/her reliance on You for maintenance and support due to his/her condition be supplied to Us after said Dependent attains the limiting age shown in the definition of Dependent.

If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

{Dependent coverage may only be terminated when certain life change events occur including death, divorce or reaching the limiting age {or during open enrollment periods.} {unless otherwise specified in any applicable Late Entrant Rider to the Certificate of Insurance.}}

The following provision is added to the "Late Enrollment" subsection(s) of the Certificate:

**Late Enrollment**

In the instance where a Certificate Holder is required by a court or administrative order, or in cases being enforced under Title IC-D of the Social Security Act by the Office of Child Support Enforcement as required by Arkansas law, to provide health coverage for an unmarried child, and the Certificate Holder fails to make application to obtain coverage for the child, We will enroll the child upon application of the child's other parent, or the state agency administering the federal child enforcement program. We will not disenroll or eliminate coverage of the child unless provided with written evidence that the court or administrative order is no longer in effect, or that the child is or will receive coverage through another plan with an effective date no later than the effective date of disenrollment.

The "Coordination of Benefits" subsection of the "BENEFITS" section of the Certificate is completely removed and replaced with the following:

**Coordination of Benefits (COB)**

The Coordination of Benefits ("COB") provision applies when a Member has health care coverage under more than one Plan (defined below). The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed one-hundred percent (100%) of the total Allowable Expense (defined below).

1. The following words/phrases regarding Coordination of Benefits ("COB") are defined as set forth below:

A. **Plan**, for the purpose of this COB section, is any of these which provides benefits or services for, medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts:

(1) **Plan** includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage, whether insured or uninsured. "Plan" also includes medical care components of long-term care contracts, such as skilled nursing care, medical benefits under group or individual automobile contracts and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal government plans, unless permitted by law.

B. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans.

C. The **Order of Benefit Determination Rules** state whether this Plan is a Primary Plan or a Secondary Plan when the Member has health care coverage under more than one Plan.

(1) When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

(2) When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits and may reduce the benefits it pays so that all Plan benefits do not exceed one-hundred percent (100%) of the total allowable expense.

D. **Allowable Expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by a Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered Member is not an Allowable Expense.

(1) The following are examples of expenses that are not Allowable Expenses:

a. The difference between the cost of a resin-based composite filling and the cost of an amalgam filling is not an Allowable Expense unless one of the Plans provides coverage for resin-based composite fillings.

b. If a Member is covered by two (2) or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

- c. If a Member is covered by two (2) or more Plans that provide benefit payment on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- d. If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
- e. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. **Closed Panel Plan** is a Plan that provides health care benefits to covered person's primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the Parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## 2. Order of Benefit Determination Rules

When a Member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B. (1) Except as provided in Paragraph (2) below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this rule is always primary unless the provisions of both plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policyholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculation payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent/Dependent. The Plan which covers the Member other than as dependent, for example as an employee, member, policyholder, subscriber or retiree is

the Primary Plan and the Plan that covers the Member as a dependent is the Secondary Plan. However, if the Member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Member as a dependent; and primary to the Plan covering the Member as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Member as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in a calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that has covered the parent longest is the Primary Plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan of the parent with custody of the child;

(b) The Plan of the spouse of the parent with the custody of the child;

(c) The Plan of the parent not having custody of the child; and

(d) The Plan of the spouse of the parent not having the custody of the child;

(2) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the dependent child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;

(3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subpart 2.D.(2)a above shall determine the order of benefits.

(4) If the court decree states that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses of the dependent child, the provisions of subpart 2.D.(2)a above shall determine the order of benefits.

c. For a dependent child covered under more than one Plan of individuals who are not parents of the child, the provisions of subparts 2.D.(2)a or 2.D.(2)b above shall determine the order of benefits as if those individuals were the parents of the child.

E. Active Employees or Retired or Laid-Off Employees. The Plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The Plan covering the same Member as a retired or laid-off employee is the Secondary Plan. The same would hold true if a Member is a dependent of an active employee and the same Member is a dependent of a retired or laid-off employee. If the other Plan does not have this

rule, and as a result, the Plans do not agree this rule is ignored. This rule does not apply if the rule labeled D(1) of this section can determine the order of benefits.

F. COBRA or State Continuation Coverage. If a Member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the Member as an employee, member, subscriber or retiree or covering the Member as a dependent of an employee member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plans do not have this rule, and as a result, the Plans do not agree on the order of benefits this rules is ignored. This rule does not apply if the rule labeled D(1) of this section can determine the order of benefits.

G. Longer or Shorter Length of Coverage. The Plan that covered a Member as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan which covered that Member for the shorter period of time is the Secondary Plan.

H. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition this Plan will not pay more than it would have paid had it been the Primary Plan.

3. Effect on the Benefits of this Plan - When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of another health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information - Certain facts about health care coverage are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Company may get needed facts from or give them to any other organization or person to the extent reasonably necessary to apply these rules and to determine benefits payable under This Plan and other Plans covering the Member claiming benefits. The Company need not tell, or get the consent of, any person to do this. Each Member claiming benefits under This Plan must give the Company any facts it needs to apply those rules and determine benefits payable.

5. Facility of Payment - A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery - If the amount of the payments made by the Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the Members it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered Member.

4.7. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The following provision is added to the “Claims Submission” subsection of the “How the Dental Plan Works” section of the Certificate:

### **HOW THE DENTAL PLAN WORKS**

#### **Claims Submission**

For an unmarried child who has coverage through a noncustodial parent, We will provide information to the custodial parent necessary for the child to obtain benefits through that coverage.

The following provision is added to the “Payment of Benefits” subsection of the “Benefits” section of the Certificate:

### **BENEFITS**

#### **Payment of Benefits**

For an unmarried child who has coverage through a noncustodial parent who is the Certificate Holder, We will permit the custodial parent or provider, with the custodial parent’s approval, to submit claims for covered services without the approval of the noncustodial parent who is the Certificate Holder. We will make payments on claims submitted by the custodial parent or provider for covered services directly to the custodial parent, the provider or the required state agency.

The following provision and subsection are added to the “General Provisions” section(s) of the Certificate:

### **GENERAL PROVISIONS**

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Arkansas.