

SERFF Tracking Number: AMCM-127360540 State: Arkansas  
 Filing Company: American Community Mutual Insurance Company State Tracking Number: 49503  
 Company Tracking Number: AR-GP-AR (1/11)  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: Grievance & External Review Amendment  
 Project Name/Number: /

## Filing at a Glance

Company: American Community Mutual Insurance Company

Product Name: Grievance & External Review Amendment SERFF Tr Num: AMCM-127360540 State: Arkansas

TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 49503

Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: AR-GP-AR (1/11) State Status: Approved-Closed

Filing Type: Form

Author: Pat Robbins

Reviewer(s): Rosalind Minor

Date Submitted: 08/09/2011

Disposition Date: 08/09/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 08/09/2011

State Status Changed: 08/09/2011

Deemer Date:

Created By: Pat Robbins

Submitted By: Pat Robbins

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

Enclosed for your review and approval is amendment form AR-GP-AR (1/11), Internal Grievance and External Review Procedures Amendment. This amendment will be included with all health insurance products sold in the individual market. This amendment has been updated to comply with the changes required under the Patient Protection and Affordable Care Act. It will replace form GP-AR (1/09) which was approved on 10/9/2008. The following revisions are

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 included in this form:

- \*Added language indicating that a grievance can be filed within 180 days after an adverse determination is received.
- \*The definition of Adverse Determination was revised to include rescission of coverage, determination of ineligibility for coverage, and determination to reduce or terminate a previously approved course of treatment before it is concluded.
- \*The requirement that the claim involves benefits of \$500 or more to qualify for External Review has been removed.
- \*The Description of the Grievance Process was revised to include only one level of standard internal review as required under PPACA.
- \*The Description of the Grievance Process was revised to include statements regarding a full and fair review and continuation of coverage pending the outcome of the grievance.
- \*Removed the Level 2 Review under the Standard Processes and all references to the Level 2 Review.
- \*Updated the timeframe allowed to file a standard external grievance to 4 months as required under PPACA.

As indicated in the PPACA Compliance Summary attached under the Supporting Documentation Tab, all PPACA requirements, except the appeals process, are included in the previously approved amendment rider form GP-AR (1/09) which was submitted under SERFF #AMCM-127030650 and approved 3/1/2011.

## Company and Contact

### Filing Contact Information

Patricia Robbins, Sr. Compliance Specialist      probbins@american-community.com  
 39201 Seven Mile Road      734-591-4708 [Phone]  
 Livonia, MI 48152      734-591-4628 [FAX]

### Filing Company Information

American Community Mutual Insurance      CoCode: 60305      State of Domicile: Michigan  
 Company  
 39201 Seven Mile Road      Group Code:      Company Type:  
 Livonia, MI 48152      Group Name:      State ID Number:  
 (800) 991-2642 ext. [Phone]      FEIN Number: 38-1290976

## Filing Fees

Fee Required?      Yes  
 Fee Amount:      \$50.00



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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/09/2011	08/09/2011

SERFF Tracking Number: AMCM-127360540 State: Arkansas  
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(PPO)  
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## Disposition

Disposition Date: 08/09/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMCM-127360540 State: Arkansas  
 Filing Company: American Community Mutual Insurance State Tracking Number: 49503  
 Company  
 Company Tracking Number: AR-GP-AR (1/11)  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider  
 (PPO)  
 Product Name: Grievance & External Review Amendment  
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Internal Grievance & External Review Procedures	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: AR-GP-AR (1/11)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/09/2011	AR-GP-AR (1/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Internal Grievance & External Review Procedures	Initial		40.000	AR-GP-AR (1-11).pdf

**AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY**  
**(Herein Referred to as "The Company")**  
**39201 West Seven Mile Road, Livonia, Michigan 48152**

**INTERNAL GRIEVANCE AND EXTERNAL REVIEW PROCEDURES AMENDMENT**

This amendment is a part of the policy to which it is attached. It is subject to all the terms and conditions of the policy not inconsistent with it. It is effective on [the first day of the first plan year beginning on or after September 23, 2010].

The Internal Grievance and External Review Procedures included in the policy are deleted and replaced with the following:

If We deny, reduce, terminate or fail to make payment for a benefit, You or Your Authorized Representative may file a Grievance with Us within 180 days after You receive an Adverse Determination.

**Definitions**

**Adverse Determination** means a determination made by Us or Our administrator that includes any denial, reduction, or termination of, or failure by Us to make payment (in whole or in part) for a benefit, including:

1. A determination that a service is not appropriate or medically necessary;
2. A determination that a service is experimental or investigational;
3. A determination that You are not eligible for coverage under the policy;
4. A determination to reduce or terminate a previously approved course of treatment before it is concluded; and
5. A determination to rescind coverage, whether or not, in connection with the rescission, there is an adverse affect on any particular benefit at that time.

In order to qualify for External Review the Adverse Determination must be a final adverse determination except as may be provided herein.

An Adverse Determination does not include a denial based on the following:

1. An express exclusion under terms of the policy, other than medical necessity or experimental/investigational,
2. An express limitation under the terms of the policy, such as number of visits, number of treatments for a covered benefit in any given timeframe (calendar year, benefit period, lifetime),
3. An express limitation under the terms of the policy with respect to maximum dollar limits in any given timeframe (calendar year, benefit period, lifetime),
4. That the services were requested or obtained by the covered person through fraud or material misrepresentation,
5. The services or the means or methods of administering them were illegal,
6. FDA or other government agency determinations, reports or statements, or
7. Licensure, permit or accreditation status of a health care provider.

**Authorized Representative** means a person to whom You give express written consent to represent You in an External Review; a person authorized by law to provide substituted consent for You; or when You are unable to provide consent, a member of Your family or Your treating health care professional if a member of Your family is not available.

**Final Adverse Determination** means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our Internal Grievance Procedure.

**Grievance** means any dissatisfaction expressed by You or on Your behalf regarding any denial, reduction, or termination of, or failure by Us to make payment (in whole or in part) for a benefit.

**You, Your, Yours** means the insured Family Member.

**How To Contact Us**

A Grievance or new information may be submitted to Us by telephone, through the U.S. mail, by fax, or e-mail. The contact person is:

Name: [Monica Davis], [Claims Director]  
Address: American Community Mutual Insurance Company  
39201 Seven Mile Road, Livonia, MI 48152  
Telephone: [(800) 991-2642], Extension [4712]  
Fax: [(734) 591-4697]  
E-mail: [ac-grievances@American-Community.com]

**How To Contact Arkansas Commissioner of Insurance**

You may contact the Arkansas Commissioner of Insurance for assistance at any time.

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1904

Telephone: (800) 852-5494 or (501) 371-2640  
E-mail: insurance.consumer@Arkansas.gov

**DESCRIPTION OF THE GRIEVANCE REVIEW PROCESS**

There are two Grievance Review processes: An expedited process for urgent matters and a standard process.

**Expedited Process**

Expedited Internal Review  
Expedited External Review

**Standard Process**

Standard Internal Review  
Standard External Review

We will provide a full and fair review by providing the claimant, free of charge any new or additional evidence and the rationale for the adverse benefit determination.

We will provide continuation of coverage pending the outcome of a Grievance.

## INTERNAL REVIEW PROCESS

### Expedited Internal Review

You may file an expedited Grievance by calling, writing, e-mailing or faxing Your request to Us (See *How To Contact Us*). Your Grievance will be expedited if Your treating provider certifies that the time required to process Your request through the standard Grievance process would seriously jeopardize Your life, health, or ability to reach and maintain maximum function.

**Our review and decision:** We will review the Grievance and provide notice of Our decision within 72 hours after We receive the Grievance.

**If We deny Your Grievance:** You may request an expedited external review only if We determined that the service is not appropriate or medically necessary or the service is experimental or investigational. (See *Expedited External Review Procedure*)

**If We grant Your Grievance:** We will authorize the service, and the Grievance process is over.

### Standard Internal Review

You may file a standard Grievance by writing, e-mailing or faxing Your request to Us (See *How to Contact Us*).

**Our review and decision:** We will notify You of Our decision as soon as possible, but no later than 30 calendar days after We receive Your Grievance. However, if We require a 30-day extension for circumstances beyond Our control, We will notify You of the extension within 30 calendar days after We receive the Grievance.

**If We deny Your Grievance:** You may file a standard external review only if We determined that the service is not appropriate or medically necessary or the service is experimental or investigational. (See *Standard External Review Procedure*)

**If We grant Your Grievance:** We will authorize the service or pay the claim and the Grievance is over.

## EXTERNAL REVIEW PROCESS

### Standard External Review

You or Your Authorized Representative may request a Standard External Review of an Adverse Determination after You have exhausted Our Standard Internal Review Process. The request for a Standard External Review may be made before You have exhausted Our Standard Internal Review Process if We agree that the matter may proceed directly to External Review. The request must be sent to Us in writing or via electronic media within 4 months after the date You receive notice of an Adverse Determination or Final Adverse Determination.

When We receive a request for a Standard External Review, We will assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. The IRO will conduct a preliminary review of the request to determine the following:

1. The request meets the requirements applicable to an External Review;
2. You have exhausted Our internal review process, unless this requirement is waived by Us; and
3. You have provided all the information and forms, including the appropriate authorization form, required to process an External Review.

Within 5 business days after receipt of the request for External Review, the IRO will complete the preliminary review and notify You, Your treating health care professional, and Us in writing that:

1. The request is complete and has been accepted for external review; and that **any additional information and supporting documentation that the IRO should consider during its review may be submitted in writing within 7 business days following the date of receipt of the notice.**
2. The request is not complete and what information or materials are needed to make the request complete. Upon receipt of any information from You, the IRO will immediately forward copies of the information to Us. Upon receipt of this information We may reconsider the Adverse Determination or Final Adverse Determination that is the subject of the External Review. If We decide to reverse Our previous Adverse Determination or Final Adverse Determination, the External Review will be terminated.
3. The request is not accepted for external review and the reasons for its non-acceptance.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Determination or Final Adverse Determination to You, Your treating health care professional and Us.

Upon receipt of a notice of a decision by the IRO reversing the Adverse Determination or Final Adverse Determination We will immediately approve the coverage and pay the claim.

#### Expedited External Review

1. You or Your Authorized Representative may file a request for an Expedited External Review of an Adverse Determination at the same time You file a request for an Expedited Internal Review under Our Internal Grievance Procedure, if:
  - a. You have a medical condition where the timeframe to complete an Expedited Internal Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
  - b. Our denial of benefits is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies with reasoning, rationale, or evidence that the recommended service or treatment would be significantly less effective if not promptly initiated.

When We receive this type of request for an Expedited External Review, We will immediately assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. The IRO conducting the expedited external review will determine whether you will be required to exhaust the Expedited Internal Review, before it conducts the Expedited External Review. Upon a determination that You must first complete the Expedited Internal Review procedure, the IRO will immediately inform You and Your treating physician that it will not proceed with the Expedited External Review until the Expedited Internal Review is completed and the denial of benefits is upheld.

2. You or Your Authorized Representative may file a request for an Expedited External Review of a Final Adverse Determination if it concerns:
  - a. An admission, availability of care, continued stay or health care service for which You received emergency services, but you have not been discharged from a facility; or
  - b. Our denial of benefits is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies with reasoning, rationale, or evidence that the recommended service or treatment would be significantly less effective if not promptly initiated.

When We receive a request for an Expedited External Review, We will immediately assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. We will provide all documents and information considered in making the adverse determination or final adverse determination, as well as any additional information and supporting documentation We have or You have provided to Us, electronically, via facsimile or any other available expeditious method, to the IRO, You and Your treating health care professional. The IRO will conduct a review of the request to determine that the request meets the requirements applicable to an External Review.

As expeditiously as Your medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for the Expedited External Review that meets the requirements applicable to an External Review, the IRO shall make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination and notify You, Your treating health care professional and Us of the decision.

If the decision was not in writing, within 2 days after the date of providing that notice, the IRO shall provide a written or electronic media confirmation of the decision to You and Us.

Upon receipt of a notice of a decision by the IRO reversing the Adverse Determination or Final Adverse Determination We will immediately approve the coverage and pay the claim.

An Expedited External Review may not be provided for adverse or final adverse determinations involving treatment or services that have already been provided.

Signed for American Community Mutual Insurance Company at Livonia, Michigan

[Authorized Signature]

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 (PPO)  
 Product Name: Grievance & External Review Amendment  
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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	08/09/2011
<b>Comments:</b>		
<b>Attachment:</b> AR Readability (AR-GP).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	08/09/2011
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	08/09/2011
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	08/09/2011
<b>Bypass Reason:</b> N/A		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	08/09/2011
<b>Comments:</b>		

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(PPO)  
Product Name: Grievance & External Review Amendment  
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**Attachment:**

AR - PPACA Uniform Compliance Summary - GP.pdf

**AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY**  
**39201 Seven Mile Road, Livonia, Michigan 48152**  
**734-591-9000 – Fax 734-591-4628**  
**NAIC Company #60305 – NAIC Group #166**

**READABILITY CERTIFICATION**

TO: The Arkansas Department of Insurance

RE: PPACA Amendment

DATE: August 9, 2011

<u>Form Number</u>	<u>Description</u>
AR-GP-AR (1/11)	Internal Grievance & External Review Procedures

I certify that the above form meets or exceeds a score of forty (40) on the Flesch Readability Test.

Francis P. Dempsey

Digitally signed by Francis P. Dempsey  
DN: cn=Francis P. Dempsey, o=American Community  
Mutual Insurance Company, ou=Legal Department,  
email=fdempsey@american-community.com, c=US  
Date: 2011.08.09 11:02:07 -04'00'

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Francis P. Dempsey, Senior Vice President  
General Counsel & Corporate Secretary

Date: August 9, 2011

## PPACA Uniform Compliance Summary

**Please select the appropriate check box below to indicate which product is amended by this filing.**

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
- SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

**\*For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

### COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
American Community Mutual Insurance Company	60305	AMCM-125834735	IND09	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

## PPACA Uniform Compliance Summary

Reset Form

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650			
	Page Number:			
	<b>Prohibit Rescissions</b> – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number: <b>Form AR-GP-AR (1/11)</b></p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation: Included in form AR-IND09-PPACA-AR approved 3/1/2011, SERFF #AMCM-127030650</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If <b>no</b> , please explain.

## PPACA Uniform Compliance Summary

### SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Access to Pediatricians</b> – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
	<p>Explanation: Not applicable to this policy form. Designation of PCP is not required.</p>			
	<p>Page Number:</p>			
	<p><b>Access to OB/GYNs</b> – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
	<p>Explanation: Not applicable to this policy form. No authorization or referral is required.</p>			
	<p>Page Number:</p>			

**PPACA Uniform Compliance Summary**

**Reset Form**

**SECTION B – Group Health Benefit Plans (Small and Large)**

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
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	<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Annual Dollar Limits on Essential Benefits –</b> Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Eliminate Lifetime Dollar Limits on Essential Benefits</b>	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Prohibit Rescissions –</b> Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<b>Preventive Services</b> – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <sup>◇</sup> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			
	<b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	Explanation:			
	Page Number:			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

## PPACA Uniform Compliance Summary

### SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Access to Pediatricians</b> – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
	<p><b>Access to OB/GYNs</b> – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.