

SERFF Tracking Number: AGDE-128405097 State: Arkansas
 Filing Company: National Union Fire Insurance Company of Pittsburgh, Pa. State Tracking Number:
 Company Tracking Number: S30687NUFIC(REV.04-12)
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Specialty Markets
 Project Name/Number: PPACA /S30687NUFIC(Rev. 04-12)

Filing at a Glance

Company: National Union Fire Insurance Company of Pittsburgh, Pa.

Product Name: Specialty Markets SERFF Tr Num: AGDE-128405097 State: Arkansas
 TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved- State Tr Num:
 Closed
 Sub-TOI: H04.001 Student Co Tr Num: State Status: Approved-Closed
 S30687NUFIC(REV.04-12)
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Jane Ford, Gloria Jauss, Disposition Date: 06/12/2012
 David Bedwell, Veronica Bullock
 Date Submitted: 06/01/2012 Disposition Status: Approved-
 Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: PPACA Status of Filing in Domicile: Authorized
 Project Number: S30687NUFIC(Rev. 04-12) Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Other Explanation for Other Group Market Type:
 Student
 Overall Rate Impact: Filing Status Changed: 06/12/2012
 State Status Changed: 06/12/2012
 Deemer Date: Created By: Gloria Jauss
 Submitted By: Veronica Bullock Corresponding Filing Tracking Number:
 PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms
 PPACA Notes: null
 Healthcare.gov ID:
 Filing Description:
 Attached are two forms for your review and approval, pursuant to Arkansas statute 23-79-109.

SERFF Tracking Number: AGDE-128405097 State: Arkansas
Filing Company: National Union Fire Insurance Company of Pittsburgh, Pa. State Tracking Number:
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Project Name/Number: PPACA /S30687NUFIC(Rev. 04-12)

The forms will be attached to S30494NUFIC-AR (Rev. 9-11), Student Blanket Accident and Sickness Insurance Policy, which was approved by your Department on December 22, 2011. The submitted forms will bring the Policy into compliance with the Patient Protection and Affordable Care Act (PPACA).

S30687NUFIC(Rev.04-12) will bring the Policy into compliance with the grandfathered and non-grandfathered requirements of PPACA with respect to students.

S30726NUFIC-NV will bring the Policy into compliance with the PPACA requirements and Rule and Regulation 76 with respect to internal and external appeals.

Printing is subject to changes in ink, paper stock, page number, margins, positioning and format. However, printing standards will never be less than required under your law.

Also attached are an explanation of variables and the required filing certification. Thank you in advance for your attention to this filing. Please contact me if you have any questions or require additional information.

State Narrative:

Company and Contact

Filing Contact Information

Gloria Jauss, Manager gloria.jauss@chatisinsurance.com
503 Carr Road 888-396-5369 [Phone] 31732 [Ext]
3rd Floor 302-830-4466 [FAX]
Wilmington, DE 19809

Filing Company Information

National Union Fire Insurance Company of Pittsburgh, Pa. CoCode: 19445 State of Domicile: Pennsylvania
503 Carr Road Group Code: 12 Company Type:
3rd Floor Group Name: AIG State ID Number:
Wilmington, DE 19809 FEIN Number: 25-0687550
(888) 396-5369 ext. 31722[Phone]

Filing Fees

Fee Required? Yes

SERFF Tracking Number: AGDE-128405097 State: Arkansas
Filing Company: National Union Fire Insurance Company of State Tracking Number:
Pittsburgh, Pa.
Company Tracking Number: S30687NUFIC(REV.04-12)
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
Product Name: Specialty Markets
Project Name/Number: PPACA /S30687NUFIC(Rev. 04-12)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	06/12/2012	06/12/2012

SERFF Tracking Number: AGDE-128405097 *State:* Arkansas
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Pittsburgh, Pa.
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Disposition

Disposition Date: 06/12/2012

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: AGDE-128405097 State: Arkansas
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 Pittsburgh, Pa.
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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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 [GRANDFATHERED]1 [POLICY][CERTIFICATE] 2 RIDER	Approved-Closed	Yes
Form	APPEAL RIDER	Approved-Closed	Yes

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Form Schedule

Lead Form Number: S30687NUFIC(Rev. 04-12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/12/2012	S30687NUFIC(Rev.04-12)	Policy/Contract	PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 Amendments, Insert 1 Page, [POLICY][CERTIFICATE] 2 RIDER or Rider	Initial		51.800	S30687NUFIC(Rev 04-12).pdf
Approved-Closed 06/12/2012	S30726NUFIC-AR	Policy/Contract	APPEAL RIDER al Certificate: Amendments, Insert Page, Endorsement or Rider	Initial		50.100	S30726NUFIC-AR Appeal Rider.pdf

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

Policyholder: [ABC University]

Policy Number:

[XXXXXX]

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 [GRANDFATHERED]¹ [POLICY][CERTIFICATE]² RIDER

The [Policy][Certificate]², to which this Rider is attached and becomes a part, is amended as stated below. A new section titled **Patient Protection and Affordable Care Act** is hereby added to the [Policy][Certificate]² as follows:

Patient Protection and Affordable Care Act

Effective [mm/dd/yyyy], some of the benefits, terms, conditions, limitations, and exclusions contained in the [Policy][Certificate]² will change as a result of the Patient Protection and Affordable Care Act (Act).

Notwithstanding any other provision of the [Policy][Certificate]², the provisions below shall apply. In the event of a conflict between the provisions of any other Section of the [Policy][Certificate]² and the provisions of this Rider, the provisions of this Rider shall prevail, except to the extent the provisions of the [Policy][Certificate]² are more beneficial than are the provisions of this Rider.

Definitions

For the purposes of this Rider, the following definitions shall apply:

“**Essential Benefits**” means the essential health benefits defined in Section 1302(b) of the Act. This includes at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services;
- (B) Emergency services;
- (C) Hospitalization;
- (D) Maternity and newborn care;
- (E) Mental health and substance use disorder services, including behavioral health treatment;
- (F) Prescription drugs;
- (G) Rehabilitative and habilitative services and devices;
- (H) Laboratory services;
- (I) Preventive and wellness services and chronic disease management;
- (J) Pediatric services, including oral and vision care.

“**Act**” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Extension of Coverage to Dependents

If coverage includes Dependents, Dependent child coverage will continue until [the date the Dependent child turns age 26]³ [the end of the month the Dependent child turns age 26]³ [the end of the calendar year in which the Dependent child turns age 26]³ regardless of the marital status of such Dependent child. Coverage does not include the Spouse or child of such Dependent child unless that child meets other coverage criteria established under state law. [Coverage will not continue for the Dependent child that has coverage available through his or her employer.]⁴

Lifetime Dollar Limits

Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not Essential Benefits.

Rescissions

Coverage cannot be rescinded except for fraud or intentional misrepresentation of a material fact.

[Preexisting Conditions

Any Preexisting Condition exclusion or limitation does not apply to a Covered Person under age 19.]⁵

[Preventative Benefits

Coverage for preventative benefits, as defined in the Act, do not require payment of any deductible, copayment, or coinsurance.]⁵

[Internal and External Review

The Covered Person has the right to an internal and external review.]⁵

[Emergency Services

Emergency services from non-participating providers will be covered at the same benefit and cost sharing level as services provided by participating providers.]⁵

[Primary Care Physicians

If designation of a primary care physician for a child is required, the Covered Person is permitted to designate a physician who specialized in pediatrics as the child's primary care physician if the provider is in network.]⁵

[Referrals

Authorizations or referral requirement for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology are prohibited.]⁵

[Grandfathered Health Plan Disclosure Requirement

The Company believes this is a "grandfathered health plan" under the Act. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to [The Maksin Group at 800-375-6826]⁶.]¹

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:



President



Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038

(212) 458-5000

(a capital stock company, herein referred to as the Company)

Policyholder: [ABC University]

Policy Number:

[XXXXXX]

APPEAL RIDER

This Rider is attached to and made part of the Policy [as of the Policy Effective Date shown in the Policy's Application.] [effective [Month, Day, Year]. It applies only with respect to [Accidents] [or] [Sicknesses] that occur on or after that date.] It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

The **Appeal Procedures** section of the Policy is deleted and replaced with the following:

INTERNAL REVIEW PROCESS

The Company will provide written notice of the Internal Review Process to Covered Persons following any Adverse Determination.

A Covered Person may submit an Appeal within 60 days of receiving written notice of an Adverse Determination or as soon as reasonably possible. If requested, the Company will provide written forms for submission of Appeals that will inform the Covered Person of the information necessary to pursue an appeal of an Adverse Determination.

If the Appeal is incomplete, the Company will immediately notify the Covered Person what information or materials is needed to make the Appeal complete. The Company may require that the Covered Person submit such written information or materials within 10 days of the Covered Person's receipt of the written form or as soon as reasonably possible. An Appeal will be considered as received by the Company when the Company receives the written form, which the Covered Person purports to be complete.

Under circumstances where an Appeal may not contain sufficient information and the Company requests additional information, such request will not be burdensome or require such information as the Company might reasonably be expected to obtain through the Company's normal claims process.

APPEAL PROCEDURE

When an Appeal is made, the Company will assign the Appeal to a staff member who has had no prior direct involvement with the Covered Person's case to conduct the review.

The Covered Person will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits, which the Company will review without regard to whether such information was submitted or considered in the initial benefit determination. The Company will provide the Covered Person, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The review will be concluded as soon as possible in accordance with the medical exigencies of the case. Before the Company issues a determination that is based on new or additional rationale, the Covered Person will be provided, free of charge, with the rationale sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The Company will provide written notice of the Appeal determination to the Covered Person within ten (10) business days of receipt of the Appeal. In no event will an Appeal involving an Emergency Medical Condition

S30726NUFIC-AR

exceed seventy-two (72) hours. In the event that the Adverse Determination is upheld, the written notice will include the reason for the determination, including the denial code and its corresponding meaning, and a review of the entire Internal Review Process. This information will include specific contact information (address and phone number).

Information regarding external review will be provided to the Covered Person with the notice of the Adverse Determination.

COVERED PERSON'S RIGHTS

a) The Company will not terminate or in any way penalize a Covered Person who exercises the right to appeal solely on the basis of filing the Appeal.

b) Assistance

i. Upon the initiation of an Appeal, the Company will notify a Covered Person of the right to have a staff member appointed to assist her/him with understanding the Internal Review Process.

ii. A Covered Person may request such assistance at any stage of the Internal Review Process.

iii. Upon such request, the Company will appoint a staff member who has had no prior direct involvement in the case to assist the Covered Person.

c) After an Adverse Determination, a Covered Person will have the right to discuss a coverage determination with the staff member(s) who made the coverage determination.

If the Company does not adhere to all requirements of the Internal Review Process with respect to a claim, the Covered Person is deemed to have exhausted all internal appeals processes and may initiate an external review.

DEFINITIONS

As used in this Rider:

Adverse Determination means a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit.

An Adverse Determination includes a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit that is based on:

- A Covered Person's eligibility for benefits under the Policy;
- The results from the application of any utilization review;
- A determination that an item or service, for which benefits are otherwise provided, is experimental, investigational or not a Medical Necessity.

Appeal means a written request to the Company to reconsider an Adverse Determination.

Authorized Representative means an individual who the Covered Person has given express written consent to represent his or her interests during an appeal process; a person authorized by law to provide substituted consent for the Covered Person.; or, if the Covered Person is unable to provide consent, a family member of the Covered Person or the Covered Person's treating Health Care Provider.

Commissioner means the Arkansas Insurance Commissioner.

Covered Person means a person who claims to be entitled to receive benefits from the Company. References to Covered Person with respect to notifications also include the Covered Person's Authorized Representative.

Emergency Medical Condition means a medical or behavioral condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, or as determined by the attending provider, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious impairment or dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

External Review means a review that is conducted by an Independent Review Organization (IRO).

Independent Review Organization (IRO) means an organization, whose name appears on the approved listing compiled and maintained by the Commissioner pursuant to Arkansas Rule and Regulation 76, to conduct external review.

Internal Review Process means the procedure for an internal review of an Adverse Determination.

Medical Necessity means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms, in a manner that is:

- In accordance with generally accepted standards of medical practice;
- Consistent with the symptoms or treatment of the condition; and
- Not solely for anyone's convenience.

EXTERNAL REVIEW

When the Company provides notice to a Covered Person of an Adverse Determination and the Covered Person does not agree with that decision, the Covered Person may request an External Review, in writing or by electronic means, within four (4) months after receipt of such notice. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A Covered Person may make a written or oral request of an expedited External Review at the time the Covered Person receives:

- An Adverse Determination that involves an Emergency Medical Condition; and the Covered Person has filed a request for an expedited internal appeal; or
- An Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility; and the Covered Person has filed a request for an expedited internal appeal; or
- A final internal Adverse Determination that involves an Emergency Medical Condition; or
- A final internal Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility.

A request for an External Review of an Adverse Determination may be made before the Covered Person has exhausted the Company's Internal Review process whenever the Company agrees to waive the exhaustion requirement.

A Covered Person will be considered to have exhausted the Company's Internal Review process if the Covered Person:

- has filed an appeal involving an Adverse Determination with the Company; and
- except to the extent the Covered Person requested or agreed to a delay, has not received a written decision on the appeal from the Company with thirty (30) days following the date the Covered Person

filed the appeal with the Company for a pre-service claim or within sixty (60) days following the date the Covered Person files the appeal with the Company for a post-service claim.

As part of the request, the Covered Person will provide written consent authorizing the Independent Review Organization (IRO) and the Company to obtain all necessary medical records that may be required to be reviewed for the purpose of reaching a decision on the External Review.

The Company will pay the cost of the Independent Review Organization (IRO) for conducting the External Review and will not charge back the cost of the External Review to a Health Care Provider.

The Company will expedite the Covered Person's case if his or her Health Care Provider with an established clinical relationship to the Covered Person certifies in writing and provides supporting documentation that the covered Person has an Emergency Medical Condition.

Within one (1) business day of a request for External Review, or immediately for an expedited review, the Commissioner will assign an Independent Review Organization (IRO) from the list of approved Independent Review Organizations compiled and maintained by the Commissioner to conduct a preliminary review of the request to determine if:

- (a) the request for External Review meets the applicability standards pursuant to Arkansas Rule and Regulation 76;
- (b) the Covered Person has exhausted the Company's Internal Review process; and
- (c) the Covered Person has provided all the information and forms required to process an External Review.

The assignment by the Commissioner of an approved Independent Review Organization (IRO) to conduct an External Review will be done on a random basis among the approved Independent Review Organizations (IROs) qualified to conduct the particular External Review based on the nature of the Health Care Service that is the basis of the Adverse Determination and other circumstances, including conflict of interest concerns..

At any time during the External Review process, the Company may elect to cover the recommended and requested Health Care Service and terminate the review. The Company will notify, in writing, the Covered Person and all other parties involved.

In exercising its independent medical judgment in reviewing an Adverse Determination, in addition to the documents and information provided by the Company and the Covered Person, the Independent Review Organization (IRO), to the extent the information or documents are available, will consider the following in reaching a decision:

- (a) the Covered Person's medical records;
- (b) the treating Health Care Provider's professional recommendation;
- (c) consulting reports from appropriate Health Care Professionals and other documents submitted by the Company, Covered Person, or Authorized Representative, or the Covered Person's treating Health Care Provider;
- (d) the applicable terms of coverage under the Covered Person's health benefit plan to ensure that the Independent Review Organization's (IRO's) decision is not contrary to the terms of coverage;
- (e) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- (f) any applicable clinical review criteria developed and used by the Company;
- (g) if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested Health Care Service is "experimental" or "investigational", the Independent Review Organization (IRO) will also consider whether:
 - (1) the recommended or requested Health Care Service or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing the treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or

- (2) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested Health Care Service or treatment is more likely than not to be more beneficial to the Covered Person than any available standard Health Care Service or treatment and the adverse risks of the recommended or requested Health Care Service or treatment would not be substantially increased over those of available standard Health Care Services or treatments; and
- (h) the opinion of the Independent Review Organization's (IRO'S) reviewer(s) after considering the information in (a) through (g).

The Independent Review Organization (IRO) will issue a written decision not later than forty-five (45) days from the date of receipt of the request for an External Review. For an External Review that involves a determination based on an "experimental" or "investigational" Health Care Service, the Independent Review Organization (IRO) will issue a written decision not later than twenty (20) days from the date of receipt of the request for an External Review. For an expedited External Review, the Independent Review Organization (IRO) will issue a written decision not later than 72 hours from the date of receipt of the request for an External Review. The Independent Review Organization (IRO) will send a copy of its decision to uphold, reverse, or partially uphold or reverse the Adverse Determination to the Company, the Covered Person and the Commissioner. If the Covered Person's treating Health Care Provider requested the review, the Independent Review Organization (IRO) will also send a copy of its decision to the Covered Person's treating Health Care Provider. The Independent Review Organization (IRO) will include in the notice:

- (i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial, including denial codes);
- (ii) The date the examiner received the assignment to conduct the external review and the date of the examiner's decision;
- (iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- (iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Company or to the Covered Person;
- (vi) A statement that judicial review may be available to the Covered Person; and
- (vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

After a final external review decision, the Independent Review Organization (IRO) must maintain records of all claims and notices associated with the external review process for six years. The Independent Review Organization (IRO) must make such records available for examination by the Covered Person or Company upon request

Upon receipt of a notice of a decision reversing the Adverse Determination, the Company will immediately approve the coverage that was the subject of the Adverse Determination

The Independent Review Organization's (IRO) decision is binding on the Company and the Covered Person except to the extent that the Company has other remedies available under applicable state law and the Covered Person has other remedies available under applicable federal or state law.

The Company will provide any coverage determined by the Independent Review Organization's (IRO's) decision to be Medically Necessary, subject to the other terms, limitations and conditions of the Covered Person's health benefit plan.

At any time during the external, independent review process, the Company may elect to cover the recommended or requested Health Care Service and terminate the review. The Company will notify the

Covered Person and all other parties involved by mail or, with consent or approval of the Covered Person, by electronic means.

For further information about External Review or to request an External Review, contact the Arkansas Department of Insurance at:

[Honorable Jay Bradford
Arkansas Insurance Department
1200 West 3rd Street
Room 440-2
Little Rock, Arkansas 72201-1904

Telephone: 501-371-2600
Fax Number: 501-371-2618
Via Internet: <http://www.arkansas.gov/insurance>]

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:

A stylized handwritten signature consisting of large, bold letters, likely 'R' and 'H', with a long horizontal stroke extending to the right.

President

A cursive handwritten signature that appears to start with the letter 'D' and ends with a period.

Secretary

SERFF Tracking Number: AGDE-128405097 State: Arkansas
 Filing Company: National Union Fire Insurance Company of State Tracking Number:
 Pittsburgh, Pa.
 Company Tracking Number: S30687NUFIC(REV.04-12)
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.001 Student
 Product Name: Specialty Markets
 Project Name/Number: PPACA /S30687NUFIC(Rev. 04-12)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/12/2012
Comments:		
Attachment: Ar1 Readability Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/12/2012

Comments:
 The following applications that are used with S30494NUFIC-AR (Rev. 9-11) were approved December 22, 2011:

S30496NUFIC-AR (Rev. 9-11)
 S30497NUFIC-AR (Rev. 9-11)
 S30501NUFIC-AR (Rev. 9-11)

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	06/12/2012

Comments:

Attachment:
 PPACA Uniform Compliance Summary.pdf

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variables	Approved-Closed	06/12/2012

Comments:

Attachment:
 EOVS-30687NUFIC(Rev04-12).pdf

CERTIFICATION

National Union Fire Ins. Co. of Pittsburgh, Pa. certifies that S30687NUFIC(Rev.04-12) and S30726NUFIC-AR has been reviewed and complies with Arkansas Insurance Department guidelines identified in its Bulletin No. 11-83.

A handwritten signature in cursive script, reading "Susan E. Martin". The signature is written in black ink and is positioned above a horizontal line.

Susan E. Martin
Assistant Vice President

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
National Union Fire Insurance Company of Pittsburgh, Pa.	012-19445		S30494NUFIC	<input type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: S30687NUFIC(Rev. 04-12) - Pre-Existing Conditions			
	Page Number: Page 2			
	Eliminate Annual Dollar Limits on Essential Benefits 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 no , please explain.
	Explanation: Pursuant to Section 147.145(b)(2), annual limits are permitted for Student Health Insurance Coverage			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: S30687NUFIC(Rev. 04-12) - Lifetime Dollar Limits			
	Page Number: Page 1 bottom			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: S30687NUFIC(Rev. 04-12) - Rescissions			
	Page Number: Page 2			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation: S30687NUFIC(Rev. 04-12) - Preventative Benefits</p> <p>Page Number: Page 2</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation: S30687NUFIC(Rev. 04-12) - Extension of Coverage to Dependents</p> <p>Page Number: Page 1</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation: S30726NUFIC-AR - Appeal Rider</p> <p>Page Number: Pages 1 - 4</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 no , please explain.
	<p>Emergency Services – 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: S30687NUFIC(Rev. 04-12) - Emergency Services</p> <p>Page Number: Page 2</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – 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: S30687NUFIC(Rev. 04-12) - Primary Care Physicians</p> <p>Page Number: Page 2</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation: S30687NUFIC(Rev. 04-12) - Referrals</p> <p>Page Number: Page 2</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</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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	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – 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"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – 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 no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , 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
	Preventive Services – 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 no , please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – 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 [◇] <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Appeals Process – 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 no , 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>Emergency Services – 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	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to Pediatricians – 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	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – 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	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

Explanation of Variables

S30687NUFIC(Rev.04-12) – Patient Protection and Affordable Care Act of 2010 [Grandfathered][Policy][Certificate] Rider

1. This language will print when the policy to which it is attached is a grandfathered policy as defined in the Act;
2. The word “Policy” will print when the Rider is attached to the Policy; the word “Certificate” will print when the Rider is attached to the Certificate;
3. One of these three dates will print depending upon plan design;
4. This language will be included or excluded depending upon plan design;
5. This language will print when the policy to which it is attached is a non-grandfathered policy as defined in the Act;
6. This language is variable to allow for the contact information to be updated.