

<i>SERFF Tracking Number:</i>	<i>UHLC-126219643</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare Insurance Company</i>	<i>State Tracking Number:</i>	<i>42856</i>
<i>Company Tracking Number:</i>	<i>UCC-POL-AMEND 2009 FED -AR</i>		
<i>TOI:</i>	<i>H09G Group Health - Organ &amp; Tissue Transplant - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H09G.000 Health - Organ &amp; Tissue Transplant - Limited Benefit</i>
<i>Product Name:</i>	<i>Federal Amendment</i>		
<i>Project Name/Number:</i>	<i>URN/</i>		

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: Federal Amendment

SERFF Tr Num: UHLC-126219643 State: ArkansasLH

TOI: H09G Group Health - Organ & Tissue

SERFF Status: Closed

State Tr Num: 42856

Transplant - Limited Benefit

Sub-TOI: H09G.000 Health - Organ & Tissue

Co Tr Num: UCC-POL-AMEND

State Status: Approved-Closed

Transplant - Limited Benefit

2009 FED -AR

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Jayne Jackowski, Lynn

Disposition Date: 07/09/2009

Kaisershot

Date Submitted: 07/07/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: URN

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 07/09/2009

Explanation for Other Group Market Type:

State Status Changed: 07/09/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This amendment form is being filed for large employer groups. Once approved, the amendment form will be used in conjunction with our previously approved policy/certificate series UCC-POL-AR(02-04) et al., approved by your Department on July 6, 2004.

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The intent of this amendment filing is to:

„X Add heart/kidney and cord blood transplants to the list of covered transplants outlined in Section 1., Schedule of Benefits. This addition is for clarification purposes only, as both transplant types are eligible for coverage under the Policy.

„X Update our policy/certificate forms to reflect recent changes in the Federal Children's Health Insurance Program Reauthorization Act of 2009.

„X Update our policy/certificate forms to reflect the requirements of H.R. 2851, otherwise known as "Michelle's Law".

„X Update [[Section 7]: Complaint Procedures] to reflect current regulatory requirements.

These materials represent final printed format with the exception of variable text, which is enclosed in [brackets]. We would like to reserve the right to build the amendatory language into the Policy/Certificate or leave it in the amendment format, whichever we deem most appropriate for the group.

## Company and Contact

### Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst	Jayne.Jackowski@eams.com
3100 AMS Blvd.	(920) 661-2234 [Phone]
Green Bay, WI 54313	(920) 661-9861[FAX]

### Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
450 Columbus Boulevard	Group Code: 707	Company Type: Life and Health
PO Box 150450		
Hartford, CT 06115-0450	Group Name:	State ID Number:
(860) 702-5000 ext. [Phone]	FEIN Number: 36-2739571	
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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00

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<b>Retaliatory?</b>	<b>No</b>		
<b>Fee Explanation:</b>			
<b>Per Company:</b>	<b>No</b>		

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$20.00	07/07/2009	29035665

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	07/09/2009	07/09/2009

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## **Disposition**

Disposition Date: 07/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Form</b>	Policy Amendment	Approved-Closed	Yes

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## Form Schedule

Lead Form Number: UCC-POL-Amend 2009 Fed -AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	UCC-POL-2009 Fed - AR	Policy/Cont ract/Fratern al	Policy Amendment	Initial			UCC-POL-Amend 2009 Fed-MN.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					

**UnitedHealthcare Insurance Company**

**450 Columbus Boulevard**

**Hartford, Connecticut**

**(Home Office)**

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**Policyholder: [XXXX]**

**Policy Number: [XXXXXX]**

This Amendment/Rider, effective [xxxx xx, 20xx], amends the Policy/Certificate of Coverage as follows:

**1. The second paragraph under Section 1. Schedule of Benefits is replaced with the following:**

Coverage is provided for Transplant Services for: kidney, pancreas, simultaneous kidney/pancreas, pancreas after kidney, liver and kidney, heart, single and double lung, heart/lung, heart/kidney, liver/cadaveric, liver/live donor, bone marrow, cord blood and peripheral stem cell transplants.

**2. The following is added to Special Enrollment Period as described in [Section 4.7] Special Enrollment Period:**

**[4.7] Special Enrollment Period**

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period [or Open Enrollment Period] may also enroll for Coverage during a special enrollment period if:

(a) The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date of determination of subsidy eligibility.

(b) The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Eligibility Period [or Open Enrollment Period], and coverage under the prior plan was terminated as a result of the Eligible Person and/or Dependent losing eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage under the Policy is effective only if the Company receives any required Premium and a properly completed enrollment form within 60 days of the date coverage under the prior plan ended.

**[4.] [Section 7]: Complaint Procedures, is replaced with the following:**

**[Section 7]: Questions, Complaints and Appeals**

To resolve a question, complaint, or appeal, just follow these steps:

**[7.1] What to Do if You Have a Question**

Contact the Company's Member Services Department at the telephone number shown on your [Transplant] ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

**[7.2] What to Do if You Have a Complaint**

Contact the Company's Member Services Department at the telephone number shown on your ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Company in writing, the Member Services representative can provide you with the appropriate address.

If the Member Services representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. The Company will notify you of the Company's decision regarding your complaint within 60 days of receiving it.

### **[7.3] How to Appeal a Claim Decision**

#### **Post-service Claims**

Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

#### **Pre-service Requests for Benefits**

Pre-service requests for benefits are those requests that require notification or benefit confirmation prior to receiving medical care.

#### **How to Request an Appeal**

If you disagree with either a pre-service request for benefits determination or post-service claim determination, you can contact the Company in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the [Transplant] ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Company within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

#### **Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. The Company may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

### **[7.4] Appeals Determinations**

#### **Pre-service Requests for Benefits and Post-service Claim Appeals**

For procedures associated with urgent requests for benefits, see *Urgent Appeals That Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to the Company within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

**Urgent Appeals that Require Immediate Action**

Your appeal may require immediate action if a delay in Transplant related treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call the Company as soon as possible.
- The Company will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If the Company needs more information from your Physician to make a decision, the Company will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

**All other provisions of the Policy/Certificate of Coverage remain unchanged.**



[Thomas J. McGuire  
Deputy General Counsel]

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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 07/09/2009  
**Comments:**  
**Attachment:**  
ARFleschAMD-fed.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 07/09/2009  
**Bypass Reason:** Not applicable-Policy Amendment  
**Comments:**

United HealthCare Insurance Company  
Hartford, Connecticut  
NAIC #79413

**CERTIFICATION OF COMPLIANCE**

This is to certify that the accompanying forms comply with your state's readability requirements:

**A. Option Selected**

The forms are scored separately for the Flesch reading ease test. Flesch Score is indicated below.

<u>Form</u>	<u>Flesch Score</u>
UCC-POL-Amend 2009 Fed -AR	48.8

**B. Test Option Selected**

Test was applied to each entire policy form.

**C. Standards for Certification**

A checked block indicates the standard has been achieved.

- 1. The form text achieves a minimum score of 40 on the Flesch reading ease test in accordance with the option chosen in Section A above.
- 2. It is printed in not less than ten point type, one point leaded.
- 3. The layout and spacing of the policy forms separate the paragraphs from each other and from the border of the paper.
- 4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
- 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the forms.



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**Juanita B. Luis, Assistant Secretary**

Date: July 7, 2009