

SERFF Tracking Number: UHLC-126286440 State: Arkansas
Filing Company: United HealthCare Insurance Company State Tracking Number: 43368
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Orthotics and Prosthetics Amendment Insurance
Project Name/Number: /

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: Orthotics and Prosthetics SERFF Tr Num: UHLC-126286440 State: Arkansas

Amendment Insurance

TOI: H21 Health - Other

SERFF Status: Closed-Approved- State Tr Num: 43368
Closed

Sub-TOI: H21.000 Health - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Ebony Terry

Disposition Date: 09/22/2009

Date Submitted: 08/28/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

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: Small and Large

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/22/2009

Explanation for Other Group Market Type:

State Status Changed: 09/22/2009

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

Filing Description:

The purpose of the form is to comply with the 2009 Mandates for Orthotics and Prosthetics.

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony_N_Terry@uhc.com

4 Taft Court

301-838-5611 [Phone]

Rockville, MD 20850

301-838-5676 [FAX]

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Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	1 Form x 50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	\$50.00	08/28/2009	30198389

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/22/2009	09/22/2009

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Disposition

Disposition Date: 09/22/2009

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Prosthetics and Orthotics Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: ProstheticsandOrthoticsAMD.I.01.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/22/2009	Prosthetics andOrthotics sAMD.I.01. AR	Certificate t, Insert Page, Endorseme nt or Rider	Prosthetics and Orthotics Amendment	Initial			2001 UHIC Prosthetics and Orthotics Amendment 8.28.09.pdf

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/22/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	09/22/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/22/2009
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/22/2009
Bypass Reason:	N/A		
Comments:			
Satisfied - Item:	Cover Letter	Approved-Closed	09/22/2009
Comments:			
Attachment:			
UHIC 2001 Orthotics and Prosthetic Amendment Cover.pdf			

August 28, 2009,

Via U.S. Mail

Rosalyn Minor

Arkansas Insurance Department

1200 West 3rd Street

Little Rock, Arkansas 72201

NAIC: 79413 UnitedHealthcare Insurance Company,

Form # ProstheticsandOrthoticsAMD.I.01.AR

Dear Ms. Minor,

On behalf of UnitedHealthcare Insurance Company, please accept this correspondence as a submission of the above referenced Amendment Form for the Arkansas Insurance Department's ("the Department") review. The purpose of this form is to comply with the 2009 mandates for Orthotics and Prosthetics.

This submission has been submitted electronically via SERFF and United Healthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 301.838.5611, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry

Compliance Analyst

Enclosure

ENT

Prosthetics and Orthotics Amendment

*As described in this Amendment, the Policy is modified to provide and revise Benefits for **Orthotics Devices and Services and Prosthetic Devices and Services**.*

Product Design [Para] Note to Contract Issuance: Include only if the Amendment is to be mailed separate from the COC and if the 2001 series is modified by other amendments. Do not include when amendment is issued as part of the COC. ¹Include applicable reference to law (insurance law usually, or in some states HMO law reference may be needed).

Because this Amendment reflects changes in requirements of ¹[Insurance] law of the State of Arkansas, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Group [text] ¹Include if new definitions are added to Section 10.

*Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Certificate of Coverage (Certificate) in (Section 10: Glossary of Defined Terms) ¹and in this **Amendment below**].*

Section 1: What's Covered--Benefits

Durable Medical Equipment in the Certificate of Coverage, (Section 1: What's Covered--Benefits) is replaced with the following:

Product Design [Para] Note to Contract Issuance: The bracketed covered health service number will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC where permitted.

Benefit Information

[Description of
Covered Health Service]

[Must
You
Notify Us?]

[Your Copayment
Amount
% Copayments are
based on a percent of
Eligible Expenses]

[Does
Copayment
Help Meet Out-
of-Pocket
Maximum?]

[Do You Need
to Meet Annual
Deductible?]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
Group [text] Must You Notify Us Column: ¹ Include when group chooses a plan with an annual DME limit of more than \$1,000.	<u>Network</u> [Yes][No]	[[0 - 50] %] [No Copayment]	[Yes][No]	[Yes][No]
Group [text] Must You Notify Us Column: ² Include when group chooses a plan with an annual DME limit of \$1,000 or less per year.	<u>Non-Network</u> [Yes][No]			

1. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.)
- Delivery pumps for tube feedings (including tubing and connectors.)

[Description of Covered Health Service]

[Must You Notify Us?]

[Your Copayment Amount]
% Copayments are based on a percent of Eligible Expenses]

[Does Copayment Help Meet Out-of-Pocket Maximum?]

[Do You Need to Meet Annual Deductible?]

- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage.)

Group [text] ¹Include when group chooses a plan with DME purchase of every two-five years. The standard is once every three years.
Group [text] ²Include when group chooses a plan with DME purchase of once every year.

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every [¹two-five] [calendar] [Policy] [¹years][²year].

We will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify.

Group [Para] Include when a group chooses to limit benefit.
Group [text] ¹Insert benefit limit selected by group. Standard options are \$750, \$1,000, \$1,500, \$2,000 or \$2,500.

[Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [¹\$750 - \$10,000] per [calendar] [Policy] year.]

[Description of Covered Health Service]

[Must You Notify Us?]

[Your Copayment Amount]

% Copayments are based on a percent of Eligible Expenses]

[Does Copayment Help Meet Out-of-Pocket Maximum?]

[Do You Need to Meet Annual Deductible?]

Group [Para] Include when group chooses a plan with an annual DME limit of more than \$1,000. When this option is selected, the Must You Notify Us? column should read "Yes for items more than \$1,000." If a group chooses a plan with an annual DME limit of \$1,000 or less per year, remove the entire notification requirement language and select "No" in the "Must You Notify Us?" column.

[Notify Us]

Please remember that for Non-Network Benefits you must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.]

Prosthetics Devices in the Certificate of Coverage, (Section 1: What's Covered--Benefits) is replaced with the following:

Product Design [Para] Note to Contract Issuance: The bracketed covered health service number will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC where permitted.

Benefit Information

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
<p>[20.] Prosthetic Devices and Services Benefits are available for the evaluation and treatment of a condition that requires the use of a prosthetic device.</p>	<p><u>Network</u> [Yes][No]</p>	<p>[[0 - 50] %] [No Copayment]</p>	<p>[Yes][No]</p>	<p>[Yes][No]</p>
<p>Benefits are available for external prosthetic devices that replace a limb or a body part, limited to:</p> <ul style="list-style-type: none"> • Artificial arms, legs, feet and hands. • Artificial face, eyes, ears and nose. • Breast prosthesis as required by the <i>Women's Health and Cancer Rights Act of 1998</i>. Benefits include mastectomy bras and lymphedema stockings for the arm. 	<p><u>Non-Network</u> [Yes][No]</p>			
<p>Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for</p>				

[Description of Covered Health Service]

[Must You Notify Us?]

[Your Copayment Amount]
% Copayments are based on a percent of Eligible Expenses]

[Does Copayment Help Meet Out-of-Pocket Maximum?]

[Do You Need to Meet Annual Deductible?]

your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost. The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits for replacement are limited to a single purchase of each type of prosthetic device every three years.

The following provision is added to the Certificate of Coverage, (Section 1: What's Covered --Benefits):

Product Design [Para] Note to Contract Issuance: The bracketed covered health service number will not be included when the document is issued in amendment format only; including it will be used only to support accurately embedding amendment provisions into the COC where permitted.

[Benefit Information]

[Description of Covered Health Service]	[Must You Notify Us?]	[Your Copayment Amount % Copayments are based on a percent of Eligible Expenses]	[Does Copayment Help Meet Out-of-Pocket Maximum?]	[Do You Need to Meet Annual Deductible?]
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[28.] Orthotic Devices and Services

Benefits are available for the evaluation and treatment of a condition that requires the use of an orthotic device.

Benefits are available for external orthotic devices that restore physiological function or cosmesis to you. If more than one orthotic device can meet your functional needs, Benefits are available only for the orthotic device that meets the minimum specifications for your needs. If you purchase a orthotic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the orthotic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The orthotic device must be ordered or provided by, or under the direction of a Physician. Benefits are available for repairs and replacement when necessitated by anatomical change or normal use except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.

Network
Yes][No]

[[0 - 50]%]

[Yes][No]

[Yes][No]

Non-Network
[Yes][No]

**[Description of
Covered Health Service]**

**[Must
You
Notify Us?]**

**[Your Copayment
Amount
% Copayments are
based on a percent of
Eligible Expenses]**

**[Does
Copayment
Help Meet Out-
of-Pocket
Maximum?]**

**[Do You Need
to Meet Annual
Deductible?]**

- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen orthotic devices. Orthotic devices do not include a cane, crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that:
 - Is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
 - Has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

This exclusion does not apply to orthotics that are described under Orthotic Devices and Services in Section 1: Covered Health Services.

Benefits for replacements are limited to a single purchase of each type of orthotic device every three years.

Section 2: What's Not Covered--Exclusions

The exclusion for Medical Supplies and Appliances in the Certificate under (Section 2: What's Not Covered--Exclusions) item 3 is deleted.

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Section 10: Glossary of Defined Terms

The following new definitions are added to the Certificate under (Section 10: Glossary of Defined Terms):

Orthotic Device - an external device that is, (i) intended to restore physiological function or cosmesis to a Covered Person; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the Covered Person using the device prior to concurrent with the delivery of the device to the Covered Person.

Orthotic Service - the evaluation and treatment of a condition that requires the use of an Orthotic Device.

Prosthetic Device - an external device that is (i) intended to replace an external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom designed, fabricated, assembled, fitted, or adjusted for patient using the device prior to or concurrent with being delivered to the Covered Person.

Prosthetic Service - the evaluation and treatment of a condition that requires the use of a Prosthetic Device.

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[To continue reading, go to left column on next page.]

Product Design [Para] Note to Contract Issuance: Include Effective Date only if Amendment is to be mailed separate from the COC. Do not include effective date when the Amendment is issued as part of the COC.

[Effective Date of this Amendment: _____

(Name and Title)

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