

SERFF Tracking Number: UHLC-127101772 State: Arkansas
Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 48356
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2009 PPACA Amendment
Project Name/Number: /

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: 2009 PPACA Amendment

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: UHLC-127101772 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48356

Co Tr Num:

State Status: Approved-Closed

Author: Ebony Terry

Reviewer(s): Rosalind Minor

Date Submitted: 03/28/2011

Disposition Date: 03/30/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

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:

Overall Rate Impact:

Filing Status Changed: 03/30/2011

State Status Changed: 03/30/2011

Deemer Date:

Created By: Ebony Terry

Submitted By: Ebony Terry

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

2009 PPACA Amendment

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst

Ebony_N_Terry@uhc.com

800 King Farm Blvd.

240-632-8053 [Phone]

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Suite 500
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	Group Name:	State ID Number:
Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	03/28/2011	46040381

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/30/2011	03/30/2011

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Disposition

Disposition Date: 03/30/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	PPACA Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	PPACAAM	Certificate	PPACA Amendment	Initial			2007.2009
Closed	D.H.[07][09]	Amendmen					PPACA UHC
03/30/2011	.AR	t, Insert					of AR
		Page,					Amendment
		Endorseme					3.28.11.pdf
		nt or Rider					

Patient Protection and Affordable Care Act (PPACA) Amendment

¹*Include for Choice Plus.*

UnitedHealthcare of Arkansas, Inc. [¹and UnitedHealthcare Insurance Company]

As described in this Amendment, the Policy is modified as stated below.

Contract Issuance: *Include only if the Amendment is to be mailed separate from the COC and if the 2009 series is modified by other amendments. Do not include when amendment is issued as part of the COC.*

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

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 9: Defined Terms* and in this Amendment below.

Maximum Policy Benefit/Limits on Essential Benefits

The Maximum Policy Benefit provision in the *Schedule of Benefits*, the definition of Maximum Policy Benefit in the *Certificate* and all references to a Maximum Policy Benefit are deleted. Benefits under the Policy are not limited by a Maximum Policy Benefit.

¹*Include if the plan will not use restricted annual limits.*

Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. [¹In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable.] Essential benefits include the following:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all Benefits.

Include if the plan will use a restricted annual limit for all essential benefits.

[Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

- For plan or Policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.
- For plan or Policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.

- For plan or Policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

For plan or Policy years beginning on or after January 1, 2014 there will be no annual dollar limit on essential benefits.]

Include for non-grandfathered plans and any grandfathered plan that will have this benefit added.

¹*Include for Choice Plus. Do not include for Choice.*

[Preventive Care]

[[¹Network] Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Copayment, Coinsurance, or deductible) apply to the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.]

Include when plan design applies a pre-existing condition exclusion.

[Preexisting Conditions]

[Preexisting condition exclusions do not apply to Covered Persons under age 19. The preexisting condition exclusion in the *Certificate, Section 2: Exclusions and Limitations* is replaced with the following:

[M.] [Preexisting Conditions]

A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:
- The date you have had Continuous Creditable Coverage for 12 months.
 - The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

A preexisting condition exclusion applies to late enrollees only.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]]

Dependent Children

The following *Dependent Child Special Open Enrollment* provision is added to the *Certificate, Section 3: When Coverage Begins*:

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

All references to Full-time Student status requirements are deleted. The definition of Dependent is replaced with the following:

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [\[All references to the spouse of a Subscriber shall include a Domestic Partner.\]](#) The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

[\[The definition of Dependent also includes parents \[and grandparents\] of the Subscriber \[or the Subscriber's spouse\] \[or such other sponsored Dependents as agreed upon by us and the Enrolling Group\].\]](#)

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or have reasonable access to the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

¹[Available to include for grandfathered plans that apply this eligibility condition \(only until 01-01-2014\).](#)

- A Dependent includes any child listed above under [\[26 - 30\]](#) years of age [\[¹who is not eligible to enroll in an eligible employer-sponsored health plan \(as defined by law\)\].](#)
- A Dependent includes an unmarried dependent child age [\[26 - 30\]](#) or older who is or becomes disabled and dependent upon the Subscriber.

[\[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age \[26 - 30\].\]](#)

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

[\[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.\]](#)

Fraud or Intentional Misrepresentation of a Material Fact

The terminating provision for *Fraud, Misrepresentation or False Information* in the *Certificate, Section 4: When Coverage Ends* is replaced with the following:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Claims and Appeals

Other changes provided for under the *PPACA* impact how claims and appeals are handled and are applicable to your plan:

- You have the right to appeal a rescission of coverage determination.
- If any new or additional evidence is relied upon or generated by us during the determination of an appeal we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- With respect to any urgent request for Benefits you will receive the notice of benefit determination within 24 hours after we have received all necessary information.

Include when the state does not have the required external review process in place.

- *[The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments we will provide you with additional information concerning the process.]*

Other changes provided for under the *PPACA*:

Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these provisions. These include:

- Direct access to OB/GYN care without a referral or authorization requirement.
- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before you receive services in the emergency department of a Hospital.
- If you seek emergency care from non-Network providers in the emergency department of a Hospital your cost sharing obligations (Copayments/Coinsurance) will be the same as would be applied to care received from Network providers.

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

[Effective Date of this Amendment: _____]

(Name and Title)

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	03/30/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	03/30/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	03/30/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	03/30/2011
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	03/30/2011
Bypass Reason:	N/A		
Comments:			

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	Item Status:	Status
Satisfied - Item: Cover Letter	Approved-Closed	Date: 03/30/2011
Comments:		
Attachment:		
Cover Letter 3.28.2011.pdf		

March 28, 2011,
Via U.S. Mail

Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

NAIC: 95446 UnitedHealthcare of Arkansas, Inc.
Form # PPACAAMD.H.[07][09].AR

Dear Ms. Minor,

On behalf of UnitedHealthcare of Arkansas, Inc. please accept this correspondence as a submission of the above referenced Amendment. This form is a revised version of a previously approved form. PPACAAMD.H.[07][09].AR was approved September 07, 2010 and can be identified by SERFF tracking number UHLC-126792237. The form was revised to include the UnitedHealthcare Insurance Company as a variable option when the Amendment is to be used for our Choice Plus product.

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 240.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Respectfully,

Ebony N. Terry
Compliance Analyst
Enclosure
ENT

