

SERFF Tracking Number: HUMA-127283900 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 49273
Company Tracking Number: AR-11-003-H1
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.004 Short Term
Product Name: Arkansas STM Maintenance Filing
Project Name/Number: /

Filing at a Glance

Company: Humana Insurance Company

Product Name: Arkansas STM Maintenance Filing SERFF Tr Num: HUMA-127283900 State: Arkansas

Filing

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 49273

Sub-TOI: H16G.004 Short Term

Filing Type: Form

Co Tr Num: AR-11-003-H1

State Status: Approved-Closed

Author: Latunia Riley

Reviewer(s): Rosalind Minor

Date Submitted: 07/11/2011

Disposition Date: 07/14/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 07/14/2011

State Status Changed: 07/14/2011

Deemer Date:

Created By: Latunia Riley

Submitted By: Latunia Riley

Corresponding Filing Tracking Number: AR-11-003-H1

Filing Description:

Please see cover letter

Company and Contact

Filing Contact Information

Latunia Riley, Contract Analyst

lriley2@humana.com

2 Riverwood Place

262-408-4617 [Phone]

W24133 Riverwood Dr.

SERFF Tracking Number: HUMA-127283900 State: Arkansas
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 Product Name: Arkansas STM Maintenance Filing
 Project Name/Number: /

Suite 250
 Waukesha, WI 53188

Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	07/11/2011	49655052

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/14/2011	07/14/2011

SERFF Tracking Number: HUMA-127283900 *State:* Arkansas
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Disposition

Disposition Date: 07/14/2011

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	NAIC Transmittal Document	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Arkansas Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AR-71013-01 STM 6/2011

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 07/14/2011	AR-71013- 01 STM 6/2011	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Arkansas Rider	Initial			AR STM Certificate Resident Rider 6- 2011.pdf

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

Policyholder: [ABC Association]

Primary insured: [John Doe]

Policy Number: [12345]

Effective Date: [January 1, 2008]

This rider is attached to and made part of the *certificate* to which it is attached. Except as modified below, all *certificate* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *certificate*, expenses covered under this rider are not covered under any other provisions of the *certificate*.

The provisions in this rider are available to and are applicable to residents of the state of Arkansas. *Certificates* issued to residents of the state of Arkansas are amended by adding the following:

Children's Preventive Health Care Services

We will provide coverage for *expenses incurred* for age-appropriate *children's preventive healthcare services* for a *covered dependent* child from birth to age 19 at the following intervals:

- Birth;
- 2 weeks;
- 2 months;
- 4 months;
- 6 months;
- 9 months;
- 12 months;
- 15 months;
- 18 months;
- 2 years;
- 3 years;
- 4 years;
- 5 years;
- 6 years;
- 8 years;
- 10 years;
- 12 years;
- 14 years;
- 16 years; and
- 18 years.

Services for children's preventive healthcare services are to be rendered during a periodic review and are only covered to the extent that such *services* are provided during the course of 1 visit by or under the supervision of a *healthcare practitioner services* for:

ARKANSAS RIDER

- Routine physical examinations including history, development assessment and anticipatory guidance; and
- Laboratory services in connection with routine physical examinations.

Covered expenses are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Appropriate immunizations are subject to all *certificate* requirements including but not limited to *certificate* maximums and are exempt from *deductible, coinsurance out-of-pocket limits* and benefit maximums.

Contraceptive Drugs and Devices

Coverage is available for *expenses incurred* for the use of the contraceptive method. The FDA approved uses of contraceptive methods are:

- Implant systems;
- Devices;
- Oral; and
- Injectable medications.

Coverage will also be provided for consultations, exams, procedures and *services* provided on an outpatient basis that are related to the use of the contraceptive method.

Coverage will not be provided for abortion, abortifacient or any FDA approved emergency contraception.

Benefits for contraceptives are payable under this *certificate* the same as any other *Prescription drugs*. *Covered expenses* are subject to all *certificates* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Definitions

The following has been added to the **Definitions** section:

Children's preventive healthcare services means *healthcare practitioner*-delivered or *healthcare practitioner* supervised *services* for eligible from birth through 18 years of age, with period preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory test, in keeping with prevailing medical standards for the purposes of the section.

Dependent Coverage

The Definition of **Dependent** is amended as follows:

- 1) The seventh paragraph is replaced with the following:

ARKANSAS RIDER

Your newborn child will be covered from the moment of birth only if the pregnancy is found by a health care practitioner to have begun after your effective date and your dependents are covered on the effective date of this certificate. We must receive written notice of the birth and any required premium within 90 days of the birth. If these requirements are not met, the newborn child will not be a covered person under this certificate. If you are the only covered person on this certificate, your first newborn child may be added to this certificate if we receive written notice of the birth and any required premium within 90 days of the birth. If these requirements are not met, the newborn child will not be a covered person under this certificate.

2) The eighth paragraph is replaced with the following:

A newly adopted child can be added as a *dependent* from the moment of adoption or placement for adoption in *your* residence only if *your dependents* are covered under this *certificate* on the *effective date*. We must receive written notice of the adoption or placement for adoption of the child and any required premium within 60 days of the adoption or placement. If these requirements are not met, the adopted child will not be a *covered person* under this *certificate*.

Gastric Pacemaker

You must obtain preauthorization for a gastric pacemaker that is determined medically necessary to treat gastroparesis by your healthcare practitioner to be considered as a covered expense.

Benefits for a gastric pacemaker is payable is payable under this Certificate the same as any other sickness. Covered expenses are subject to all Certificates requirements including but not limited to any copayment, deductible, coinsurance out-of-pocket limits and benefit and Certificate maximums.

Gastric pacemaker means a medical device that uses an external programmer and implanted electrical leads to the stomach and sends low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

Inherited Metabolic Disorders

Coverage will be provided for phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism if:

- Medical food or low protein modified food are prescribed as for therapeutic treatment;
- Products are administered under the direction of a *healthcare practitioner*; and
- Cost of the medical food products for the *covered dependent* exceeds \$2,400 per year per *covered dependent*.

Benefits for *prescription* drug formulas are payable under this *certificate* the same as any other *Prescription drug*. *Covered expenses* are subject to all *certificate* requirements including but not

ARKANSAS RIDER

limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

Mastectomy Services

The **Mastectomy services** section has been revised by adding the following to the **Your Certificate Benefits** provision:

- Confinement in a licensed *healthcare facility* not less than 48 hours for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending *healthcare practitioner* in consultation with the patient.

Speech or Hearing Impairment

Coverage will be provided for *medically necessary* care and treatment of loss or impairment of speech or hearing by a licensed speech pathologist or audiologist

Coverage will not be provided for hearing instruments or devices.

Covered expenses are subject to all *certificate* requirements including but not limited to any *deductible, coinsurance out-of-pocket limits* and benefit and *certificate* maximums.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Certificate of Readability.pdf	Approved-Closed	07/14/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Not applicable Comments:	Approved-Closed	07/14/2011

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: Not applicable Comments:	Approved-Closed	07/14/2011

	Item Status:	Status Date:
Satisfied - Item: NAIC Transmittal Document Comments: Attachment: Arkansas NAIC Transmittal Document.pdf	Approved-Closed	07/14/2011

	Item Status:	Status Date:
Satisfied - Item: Cover letter Comments: Attachment:	Approved-Closed	07/14/2011

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Filing Cover Letter.App-Enroll Only.pdf

HUMANA INSURANCE COMPANY

CERTIFICATION

I hereby certify, to the best of my knowledge and belief, that the enclosed form(s) comply(ies) with the requirements of Arkansas Insurance Code 23-80-206.

Form Number(s)

AR-71013-01 STM 6/2011

Flesch Test Reading Ease Score

48.7



Signed by: _____

Steven DeRaleau
Vice President

Date: July 11, 2011

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Humana Insurance Company 1100 Employers Blvd. Green Bay, WI 54344	Wisconsin	Life, Accident & Health	119	73288	39-1263473	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Latunia Riley (Contract Analyst) Humana Insurance Company N19 W24133 Riverwood Drive Waukesha, WI 53188	800-289-0260 ext 2617	920-632-0029	lriley2@humana.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	AR-11-003-H1
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise Group: <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance	H16G Group Health-Major Medical
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10.	Product Coding Matrix Filing Code	H16G.004 Short Term
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other <u>Rates</u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ <u>SUPPORTING DOCUMENTATION</u> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	Filing Submission Date	07/11/2011	
13	Filing Fee (If required)	Amount	\$50.00
		Check Date	EFT
		Retalutory	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		Check Number	_____
14.	Date of Domiciliary Approval	Rider unique to Arkansas	
15.	Filing Description:		
	See Cover Letter		
<div style="border: 1px solid black; padding: 5px; display: inline-block; margin: 10px auto; width: fit-content;"> View Complete Filing Description </div>			

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>	
Print Name	<u>Latunia Riley</u> Title <u>Contract Analyst</u>
Signature	<u>Latunia Riley</u> Date: <u>07/11/2011</u>

Digitally signed by Latunia Riley
DN: dc=com, dc=humad, ou=MILL, ou=Users, cn=Latunia Riley
Date: 2011.07.11 13:53:32 -0500

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		AR-11-003-H1
This filing corresponds to rate filing company tracking number		N/A

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Arkansas Rider	AR-71013-01 STM 6/2011	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Rider			
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number		AR-11-003-H1		
Overall percentage rate indication (when applicable)		N/A		
Overall percentage rate impact for this filing		N/A %		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1

July 11, 2011

Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

**RE: Humana Insurance Company
Group Health Form Filing
Arkansas Rider: AR- 71013-01 STM 6/2011
NAIC #73288
FEIN # 39-1263473**

Dear Sir/Madam:

We are enclosing the above-referenced form for your review and approval. This form is new and will not replace any previously filed or approved Certificates.

AR-71013-01STM 6/2011 is being filed to add coverage for gastric pacemakers in accordance with Arkansas Insurance Code 23-99-418 which is located in red, in the body of the rider.

The language in rider AR-71013-01 STM 6/2011 may be incorporated into the body of the Certificate when issued.

Included with this submission are:

- Humana Insurance Company Certification; and
- NAIC Transmittal Document.

If you have any questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,
Humana Insurance Company

Latunia Riley

Latunia Riley
Contract Analyst