

**State:** Arkansas **Filing Company:** UnitedHealthcare of Arkansas, Inc.  
**TOI/Sub-TOI:** H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO  
**Product Name:** LG.ER.12 6/12.  
**Project Name/Number:** LG.ER. 12 AR 6/12/2

## Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.  
Product Name: LG.ER.12 6/12.  
State: Arkansas  
TOI: H16G Group Health - Major Medical  
Sub-TOI: H16G.002A Large Group Only - PPO  
Filing Type: Form  
Date Submitted: 10/05/2012  
SERFF Tr Num: UHLC-128717257  
SERFF Status: Closed-Approved  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: LG ER 12 AR 6 12  
  
Implementation: On Approval  
Date Requested:  
Author(s): Geri Shomo  
Reviewer(s): Donna Lambert (primary)  
Disposition Date: 10/11/2012  
Disposition Status: Approved  
Implementation Date:  
  
State Filing Description:

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### General Information

Project Name: LG.ER. 12 AR 6/12 Status of Filing in Domicile:  
 Project Number: 2 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: Large  
 Group Market Type: Employer Overall Rate Impact:  
 Filing Status Changed: 10/11/2012 Deemer Date:  
 State Status Changed: 10/11/2012 Submitted By: Geri Shomo  
 Created By: Geri Shomo  
 Corresponding Filing Tracking Number:  
  
 PPACA: Not PPACA-Related  
  
 PPACA Notes: null  
  
 Filing Description:  
 2012 Employer application LG ER 12 AR 6 12

### Company and Contact

#### Filing Contact Information

Geri Shomo, Sr Compliance Analyst geri\_shomo@uhc.com  
 3803 N Elm Street 336-540-2206 [Phone]  
 Greensboro, NC 27455 336-545-5099 [FAX]

#### 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 Group Name: State ID Number:  
 300 FEIN Number: 63-1036819  
 Little Rock, AK 72205  
 (952) 992-7428 ext. [Phone]

### Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

Company	Amount	Date Processed	Transaction #
UnitedHealthcare of Arkansas, Inc.	\$50.00	10/05/2012	63497188

State: Arkansas

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/11/2012	10/11/2012

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	10/10/2012	10/10/2012

#### Response Letters

Responded By	Created On	Date Submitted
Geri Shomo	10/11/2012	10/11/2012

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## Disposition

Disposition Date: 10/11/2012

Implementation Date:

Status: Approved

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment: In the future, please do not indicate in your cover letter that forms are attached when they are not. Thank you so much.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Employer Apps Cover Letter	Approved	Yes
Form	LG ER 12 AR 6 12	Approved	Yes

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/10/2012
Submitted Date	10/10/2012
Respond By Date	11/12/2012

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Dear Geri Shomo,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*- Employer Apps Cover Letter (Supporting Document)*

*Comments: The cover letter references two forms, but only one has been submitted for review. Please clarify this.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Donna Lambert*

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## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/11/2012
Submitted Date	10/11/2012

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Dear Donna Lambert,

**Introduction:**

**Response 1**

**Comments:**

The cover letter was intended for both forms submitted the SB and LG, however the forms are submitted separately for SB and LG, under the same cover letter. Please do not hesitate to contact me at 336-707-1703 or geri\_shomo@uhc.com if I may be of any further assistance.

**Related Objection 1**

Applies To:

- Employer Apps Cover Letter (Supporting Document)

Comments: The cover letter references two forms, but only one has been submitted for review. Please clarify this.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

**Conclusion:**

Sincerely,

Geri Shomo

State: Arkansas

Filing Company:

UnitedHealthcare of Arkansas, Inc.

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## Form Schedule

Lead Form Number: LG ER 12 AR 6 12

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved 10/11/2012	LG ER 12 AR 6 12	OTH	LG ER 12 AR 6 12	Initial:	50.200	LG.ER.12.AR 6 12.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



**General Information (continued)**

- Yes  No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
- 
- Yes  No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
- 
- Yes  No Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?
- If you answered Yes, then by signing this application you agree with the certification in this section.
- I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.
- 
- Yes  No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

**Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence?**

(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- Last Day worked (following the last day worked for the minimum hours required to be eligible)
- 3 Months (following the last day worked for the minimum hours required to be eligible)
- 6 Months (following the last day worked for the minimum hours required to be eligible)
- UnitedHealthcare Policy Special Provisions Related to Medical Eligibility\*
- No, we do not offer medical coverage during a leave of absence

**\*UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

**HRA and Supplemental Insurance Information**

**Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?**

Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.

HRA  Yes  No

If yes, please identify type:  UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare)  Other Administrator HRA

HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement  Yes  No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

**HRA/HSA Employer Premium Contribution**

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

## HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA / HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed?  Yes  No

Who will provide account balances to UnitedHealthcare?

## Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?

Yes  No If Yes, please provide policy number \_\_\_\_\_ and Coverage Begin Date \_\_\_/\_\_\_/\_\_\_ End Date \_\_\_/\_\_\_/\_\_\_

Has this group been covered for major dental services for the previous 12 consecutive months?  Yes  No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	<input type="checkbox"/> None			
Current Dental Carrier	<input type="checkbox"/> None			
Current Life Carrier	<input type="checkbox"/> None			
Current Disability Carrier	<input type="checkbox"/> None			

## Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

**IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.**

- Yes  No
1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?
  2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?
  3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?
  4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?
  5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?
  6. Is any employee or dependent currently hospitalized?
  7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?
 

<input type="checkbox"/> Cancer (any type)	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Lung disease or respiratory problem (any type)	<input type="checkbox"/> Morbid obesity
<input type="checkbox"/> Heart disease or disorder (any type)	<input type="checkbox"/> Congenital abnormality
<input type="checkbox"/> Organ, tissue or cell transplant	<input type="checkbox"/> Vascular disease (any type)
<input type="checkbox"/> Liver disease (any type)	<input type="checkbox"/> Neurological disorder (any type)
<input type="checkbox"/> Kidney disease (any type)	<input type="checkbox"/> Immunological disorder (reportable types)
<input type="checkbox"/> Pancreatic disorder (any type)	<input type="checkbox"/> Alcohol or drug addiction or abuse
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia or Blood disorder (any type)

If you have answered "Yes" to any of the questions above, please provide the requested information on the next page for each individual. If necessary, use additional sheets of paper.

**Disclosures (continued)**

Question Number	Check One		Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	\$ Amount of Claims	Current Treatment
	Employee	Dependent							

**Important Information**

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information, or conceals information for the purpose of misleading, in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. We may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

**Signature** (Form must be signed)

Group/Company Signature \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_

**DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**

**Broker Information**

Broker Name		Agency		Agent Code/Tax ID Number	
Signature		Email Address		Social Security #	
				Phone Number	
				Date	
Commissions payable to			Broker Commission Schedule _____ Std Scale of _____ %		
Street Address		City		State	Zip Code
Rep Name			Rep #		

SERFF Tracking #:

UHLC-128717257

State Tracking #:

Company Tracking #:

LG ER 12 AR 6 12

State: Arkansas

Filing Company:

UnitedHealthcare of Arkansas, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: LG.ER.12 6/12.

Project Name/Number: LG.ER. 12 AR 6/12/2

### Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved	10/11/2012
Bypass Reason:	Documented under the form, actual score 50.2		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	10/11/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	10/11/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Employer Apps Cover Letter	Approved	10/11/2012
Comments:			
Attachment(s):			
2012 AR DOI Employer Application Cover Letter.pdf			



10/05/2012

Ms. Rosalyn Minor  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas, Inc. / NAIC No. 95446 / HMO.  
UnitedHealthcare Insurance Company / NAIC No. 79413 / INS.  
UnitedHealthcare Insurance Company of the River Valley / NAIC No. 12231 / INS.

Enrollment/Application Filings

Dear Ms: Minor

On behalf of:

UnitedHealthcare of Arkansas, Inc. / NAIC No. 95446 / HMO.  
UnitedHealthcare Insurance Company / NAIC No. 79413 / INS.  
UnitedHealthcare Insurance Company of the River Valley / NAIC No. 12231 / INS.

I am submitting the enclosed enrollment forms for your Department's review and approval.

<u>Form Number</u>	<u>Description</u>	<u>Flesch Score</u>
SB.ER.12.[AR] 06/12	Employer Application	40.1
LG.ER.12.[AR] 06/12	Employer Application	50.2

These forms are our standard forms and have been prepared for use in your state for group sizes 2-99 and 100+, as applicable, for medical, dental, vision and ancillary products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Geri Shomo, JD.  
UnitedHealthcare Insurance Company  
3803 N Elm Street  
Ph: 336-540-2206  
Fax: 336-545-5099 Email: geri\_shomo@uhc.com