

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company of the River Valley
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003A Small Group Only - PPO
Product Name: SB.ER.12 6/12.
Project Name/Number: SB.ER. 12 AR 6/12/6

Filing at a Glance

Company: UnitedHealthcare Insurance Company of the River Valley
Product Name: SB.ER.12 6/12.
State: Arkansas
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.003A Small Group Only - PPO
Filing Type: Form
Date Submitted: 10/05/2012
SERFF Tr Num: UHLC-128717281
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: SB ER 12 AR 6 12

Implementation: On Approval
Date Requested:
Author(s): Geri Shomo
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/11/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company of the River Valley
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General Information

Project Name: SB.ER. 12 AR 6/12 Status of Filing in Domicile:
 Project Number: 6 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 SB 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 Insurance CoCode: 12231 State of Domicile: Illinois
 Company of the River Valley Group Code: 707 Company Type: Health
 1300 River Drive, Suite 200 Group Name: State ID Number:
 Moline, IL 61265 FEIN Number: 20-1902768
 (309) 765-1485 ext. [Phone]

Filing Fees

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

Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company of the River Valley	\$50.00	10/05/2012	63498363

SERFF Tracking #:

UHLC-128717281

State Tracking #:

Company Tracking #:

SB ER 12 AR 6 12

State:

Arkansas

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/11/2012	10/11/2012

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Disposition

Disposition Date: 10/11/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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	Employer Apps Cover Letter	Approved-Closed	Yes
Form	SB ER 12 AR 6 12	Approved-Closed	Yes

State: Arkansas

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Form Schedule

Lead Form Number: SB 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-Closed 10/11/2012	SB ER 12 AR 6 12	OTH	SB ER 12 AR 6 12	Initial:	40.100	SB.ER.12.AR 6 12.pdf

Form Type Legend:

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

Employer Application for Small Business



[Groups with [2-50] Eligible Employees]

To avoid processing delays, please make sure you:

- 1 Answer all questions completely and accurately.
- 2 Complete and submit the Product and Benefit Selection Form, if applicable.
- 3 Submit the most recent billing statement listing those currently insured and current status.
- 4 Submit most recent wage and tax information.
- 5 Include a deposit check for any required premiums.

UnitedHealthcare of Arkansas, Inc.
 UnitedHealthcare Insurance Company
 UnitedHealthcare Insurance Company of the River Valley

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

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address

Tax ID

City

State

Zip Code

Names of Owners/Partners (if applicable)

Internet access?
 Yes No

Contact Person

Telephone

Email Address

Fax

Billing Address (If Different)

of Years in Business

Organization Type Partnership C-Corp S-Corp LLC/LLP
 Ind. Contractor Sole Proprietor Other _____

Nature of Business

Industry (SIC) Code

Multi-Location Group* Yes No

Locations

Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation
 Yes No

[Domestic Partner Coverage]
 Yes No

Waiting Period for new hires

- 1st of Policy Month following Date of Hire
 1st of Policy Month following ____ [months] [days] of employment
 Date of Hire (no waiting period)
 ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees
 Yes No

Medical Benefit Plan Option
 Calendar Year
 Policy Year

Have Workers' Comp
 Yes No

Workers' Comp Carrier Name

Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability:
 See Attached List None

Classes Excluded: None Union Hourly
 Non-Management Salary

By checking this box, I acknowledge that I do NOT want UnitedHealthcare to act as my COBRA or state continuation of coverage administrator.

Participation	# Employees Applying for:	# Employees Waiving for:	Contribution	Employer %	Employer % for Dep
# Eligible Employees working in AR _____	Medical	Medical	Medical		
	Dental	Dental	Dental		
# Eligible Employees working outside AR _____	Vision	Vision	Vision		
	Basic Life/AD&D	Basic Life/AD&D	Basic Life/AD&D		
# Ineligible Employees _____	Dep Life	Dep Life	Dep Life		
	Supp Life/AD&D	Supp Life/AD&D	Supp Life/AD&D		
Total # Employees <input type="text"/>	Supp Dep Life/AD&D	Supp Dep Life/AD&D	Supp Dep Life/AD&D		
	STD	STD	STD		
# Hours per week to be eligible** _____	LTD	LTD	LTD		
	Other	Other	Other		

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Arkansas, Inc. or UnitedHealthcare Insurance Company of the River Valley
 Dental coverage provided by UnitedHealthcare Insurance Company or UnitedHealthcare of Arkansas, Inc. or UnitedHealthcare Insurance Company of the River Valley
 Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company [or Unimerica Life Insurance Company of New York]
 Vision coverage provided by UnitedHealthcare Insurance Company

General Information (continued)

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.

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.

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			

Questions Regarding Group Size

<input type="checkbox"/> COBRA <input type="checkbox"/> St. Continuation	<p>Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days during a calendar year, you must provide employees with COBRA continuation effective January 1 of the next calendar year. If your group had fewer than 20 employees during a calendar year, you must provide State Continuation effective January 1 of the next calendar year.</p>
<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Plan Primary	<p>Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.</p>
Enter the Prior Calendar Year Average Total Number of Employees <div style="border: 1px solid black; width: 80px; height: 20px; margin-left: 0;"></div>	<p>Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.</p> <p>To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).</p>
<input type="checkbox"/> Federally Compliant MH/SUD Benefits <input type="checkbox"/> Not Required	<p>Under federal law, if your group averaged 51 or more total employees (remember to include part-time and seasonal employees) during the preceding calendar year, you must provide employees with benefits compliant with federal mental health and substance use disorder parity laws and regulations (MH/SUD Parity Compliant Benefits), if your plan provides MH/SUD benefits. If your group had 50 or fewer employees, you are not required to provide MH/SUD Parity Compliant Benefits.</p>

Questions Regarding Group Size (continued)

<input type="checkbox"/> Yes <input type="checkbox"/> 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)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>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)?</p> <p>If you answered Yes, then by signing this application you agree with the certification in this section.</p> <p>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.</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any intentional misrepresentation, fraudulent statement, or omission that constitutes fraud may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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.

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

Group Authorized Signature	Title	Date
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Commission Information

Writing Broker Name	Writing Broker SSN	Is the Broker appointed with UHC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	Broker Signature	Date
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*If more than one Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.]

SERFF Tracking #:

UHLC-128717281

State Tracking #:**Company Tracking #:**

SB ER 12 AR 6 12

State:

Arkansas

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	10/11/2012
Bypass Reason:	Documented under the form, actual score 40.1		
Comments:			

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

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

		Item Status:	Status Date:
Satisfied - Item:	Employer Apps Cover Letter	Approved-Closed	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 3rd 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