

SERFF Tracking Number: HLAD-127165386 State: Arkansas
Filing Company: HMO Partners, Inc. d/b/a Health Advantage State Tracking Number: 48746
Company Tracking Number:
TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002C Any Size Group - HMO
Maintenance (HMO)
Product Name: Amendment
Project Name/Number: General Amendment/34-118 7/11, 34-122 7/11

Filing at a Glance

Company: HMO Partners, Inc. d/b/a Health Advantage

Product Name: Amendment

SERFF Tr Num: HLAD-127165386 State: Arkansas

TOI: HOrg02G Group Health Organizations -
Health Maintenance (HMO)

SERFF Status: Closed-Approved- State Tr Num: 48746
Closed

Sub-TOI: HOrg02G.002C Any Size Group -
HMO

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Author: Evelyn Laney

Reviewer(s): Rosalind Minor

Date Submitted: 05/11/2011

Disposition Date: 05/12/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 07/01/2011

Implementation Date:

State Filing Description:

General Information

Project Name: General Amendment

Status of Filing in Domicile: Pending

Project Number: 34-118 7/11, 34-122 7/11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is a state
of domicile.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 05/12/2011

State Status Changed: 05/12/2011

Deemer Date:

Created By: Evelyn Laney

Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Attached please find forms 34-118 7/11 and 34-122 7/11 for your review and approval if indicated.

These forms are general amendment for all Evidences of Coverage. They add a disclaimer and provision for groups who do not purchase a BlueCard optional benefit rider to clarify that there are no in-network benefits for services provided outside the state of Arkansas except for emergency care. We are clarifying the benefit for services provided by

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a midwife to stipulate services must be performed in a Hospital to correlate with Coverage Policy. Home delivery exclusion is also added for additional clarification. We are deleting the many exclusions because they are either outdated procedures or we have developed Coverage Policy for them and now cover them in specific cases. We are also amending the standard BlueCard language to comply with Health Advantage requirements. Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the Evidences of Coverage.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2165 [Phone]
 Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

HMO Partners, Inc. d/b/a Health Advantage	CoCode: 95442	State of Domicile: Arkansas
320 West Capitol	Group Code:	Company Type:
Little Rock, AR 72203-8069	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0747497	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HMO Partners, Inc. d/b/a Health Advantage	\$100.00	05/11/2011	47482173

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2011	05/12/2011

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Disposition

Disposition Date: 05/12/2011

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 34-118 7/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/12/2011	34-118 7/11	Certificate	Amendment Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.300	34-118 7- 11GenAmend .pdf
Approved-Closed 05/12/2011	34-122 7/11	Certificate	Amendment Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.300	34-122 7- 11GenAmend .pdf



The following Health Advantage Evidences of Coverage are hereby amended.

- Evidence of Coverage, Standard HMO, Form #31-01
- Evidence of Coverage, BlueChoice POS Plan, Form #31-02
- Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
- Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
- Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
- Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
- Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07
- Evidence of Coverage, Conversion Plan, Form #31-08
- Evidence of Coverage, HMO Arkansas, Form #31-10

The following subsection amendments are effective on July 1, 2011.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Maternity, “Midwives” is hereby amended to read as follows.

Midwives. Services provided by any lay midwife are not covered. See Subsection 4.2.5. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the Hospital utilized by the certified nurse midwife, in case there is need for assistance during the delivery.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Maternity, “Genetic Testing” is hereby amended to read as follows.

Genetic testing. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Member’s blood or tissue to determine if the Member has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Health Advantage has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual’s treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. Health Advantage has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion under situations (4), (5) or (6). Any published Health Advantage Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Miscellaneous Health Interventions, “Trans-telephonic Home Spirometry” is hereby amended to read as follows.

Trans-telephonic Home Spirometry. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, trans-telephonic home spirometry is covered for patients who have had a lung transplant.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Cerebellar Stimulator/Pacemaker”, “Cervicography”, “Dermatome Somatosensory Evoked Potentials”, “Dexamethasone infusion”, “Electron Beam Computed Tomography”, “Magnetic Innervation Therapy”, “Meniscal Allograft Transplantation”, “Peripheral Nerve Stimulators”, “Parkinson’s Disease, Treatment with Fetal Mesencephalic Transplantation”, Radio-Frequency Thermocoagulation”, “Thoracic Electrical Bioimpedance”, “Trans-telephonic Home Spirometry” and “Vacuum, Assisted Closure” are hereby deleted in their entirety. All remaining exclusions are hereby renumbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Cognitive Rehabilitation” is hereby amended to read as follows.

Cognitive Rehabilitation. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See “Glossary of Terms.” However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Evidence of Coverage, coverage is provided for Neurologic Rehabilitation Facility Services for Members with Severe Traumatic Brain Injury. See Subsection 3.[31].

SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Compression Garments” is hereby amended to read as follows.

Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this Evidence of Coverage, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Genetic Testing” is hereby amended to read as follows.

Genetic testing. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Member’s blood or tissue to determine if the Member has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Health Advantage has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual’s treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. Health Advantage has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion under situations (4), (5) or (6). Any published Health Advantage Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Percutaneous Discectomy” is hereby amended to read as follows.

Percutaneous discectomy and Radio-frequency Thermocoagulation. Any method of percutaneous discectomy, including, but not limited to, automated or manual percutaneous discectomy, laser discectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.

SPECIFIC PLAN EXCLUSIONS is hereby amended to add the following new Subsection. All remaining Subsections are hereby renumbered to correlate with the change.

Home delivery. Services and supplies received in connection with child birth in the home are not covered regardless of the Provider.

CLAIM PROCESSING AND APPEALS, “Out of Arkansas Claims,” Subsection 7.1.10 is hereby amended to read as follows.

Out-of-Arkansas Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of our service area, the State of Arkansas, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

We cover only limited healthcare services received outside of our service area. As used in this [Subsection, 7.1.10] “Out-of-Area Covered Healthcare Services” include *only emergency care or urgent care* obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by your primary care physician (“PCP”).

a. **BlueCard® Program**

- i. Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.
- ii. The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment amount, as stated in your Evidence of Coverage.

b. **Emergency Care Services:** If you experience a Medical Emergency while traveling outside the Health Advantage service area, go to the nearest Emergency or Urgent Care facility. Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
 - The negotiated price that the Host Blue makes available to us.
- i. Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

- ii. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.
 - iii. Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.
- c. **Non-Participating Healthcare Providers Outside of Our Service Area, the State of Arkansas**
- i. **Your Liability Calculation.** When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this Evidence of Coverage.
 - ii. **Exceptions.** In certain situations, we may use other payment bases, such as a billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under the Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this Evidence of Coverage.

CLAIM PROCESSING AND APPEALS, Claim Appeal to the Plan (Internal Review), 7.3.5. a. is hereby amended to read as follows.

- a. **First Level Review.** The First Level Reviewer, a person located at the Health Advantage, conducts the first level review.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

The following Health Advantage Evidence of Coverage are hereby amended.

Evidence of Coverage, Guest Membership, Form #31-09

The following subsection amendments are effective on July 1, 2011.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Flesch Certification Form HA- 34-118, 34-122.pdf	Approved-Closed	05/12/2011
Bypassed - Item: Application Bypass Reason: Not needed. Comments:	Approved-Closed	05/12/2011
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not needed. Comments:	Approved-Closed	05/12/2011
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: Not PPACA related. Comments:	Approved-Closed	05/12/2011

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

**Re: HMO Partners, Inc. d/b/a Health Advantage
Form Nos. 34-118, 34-122 5/11**

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced document has achieved a Flesch Reading Ease Score average of 40.3 and complies with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

Dail Brulje

Name

President
Title

May 11, 2011
Date